THE CRISIS IN AMERICA'S HEALTH CARE AND ITS PUBLIC POLICY IMPLICATIONS

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THESIS

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ABSTRACT

The author examines the Department of Defense program to procure and retain physicians for the armed forces. The necessity for such a program is shown to be related to the medical profession's policy of restricting entry into the profession; the resulting shortage of physicians is found to be inseparable from the national issues of health care productivity and delivery, and the present inadequacies of health care financing. A statement of the central issue is formulated, the main barriers to be overcome are identified, and a politically moderate solution is proposed through adoption of certain key policies. Such a solution is described as unlikely since it requires the support and participation of the medical profession. The alternative is a later and more severe public and political reaction, leading to an increasingly centralized national health service system.

TABLE OF CONTENTS

I. INTRODUCTION

Among its current dilemmas, the Department of Defense is attempting to solve the problem of procurement and retention of military medical officers in an all-volunteer force environment. A review of these efforts leads inevitably to the more basic issue of the national supply of physicians, and this issue, in turn, is inextricably related to the central issue of health care and medical services throughout America.

Part III of this thesis demonstrates the inseparable complexity of the major issues and defines them as appropriate subjects of public policy which are now formulated by politically oriented professional associations and related industry lobby groups. The resulting economic aspects of the present system are biased heavily in favor of the medical professions and related industries, to the detriment of adequate health care for the public. The present system of health care financing seems an exercise in total futility.

Part IV describes systems which have been implemented elsewhere in response to similar health care problems, and notes alternatives and trends currently being considered in America. In Part V, a statement of the central issue is formulated and the barriers to be overcome are identified. The thesis is advanced that a politically moderate solution can be achieved through adoption of certain key policies:

- expansion of the number of physicians;
- elimination of prohibitions on innovative forms of medical practice;
- enactment of a national health service benefits plan.

The outlook is dim for a moderate 'decentralized' solution for that requires the support and participation of the medical profession. The alternative appears to be an increasingly centralized and bureaucratic system in which the degree of socialization will likely reflect the bitterness and costliness of the struggle for change.

II. THE PHYSICIAN NEEDS OF THE ARMED FORCES

A. THE PROBLEM SETTING

Phase-out of the general draft rooted in the Selective Service Act of 1948, and the Nixon Administration's goal of the all-volunteer armed forces, has surfaced and highlighted a most critical problem in recruitment and retention of medical service professionals in such an environment. The doctor draft law, [1] which applies to all health professions, has been in use on an uninterrupted basis since 1950. Although the original law was permitted to expire in 1957, military medical manpower needs were met thereafter under the authority of the general draft, amended to provide for "selection and induction of persons qualified in needed medical, dental or allied specialist categories pursuant to requisitions submitted by the Secretary of Defense." The effect of the amended draft law was that any individual who obtained a student deferment prior to age 26 became liable for military service until age 35. The law was last extended in June 1971 for an additional two-year duration.

Despite an anticipated reduction in requirements based on an overall cutback in the standing armed forces, the administration's plan to end the draft and move to an all-volunteer force, makes it necessary that the Department of Defense (DOD) take whatever steps deemed necessary to improve the attractiveness of military medical careers.

The abolition of student deferments, combined with the lottery system which gives young men a one-time-only draft (if required) vulnerability at age 19, means that only about a seven-year's supply of persons already on student deferments would be liable to the doctor draft by the time they complete their medical education.

None of this however, precludes continuation of a doctors draft (by the congress) as necessary to meet continuing needs until such requirements are fully satisfied by voluntarism. With continuation of a regulated medical school output, procurement of professional medical talent can be expected to remain as a recruitment problem. This shortage (relative to other groups), combined with the public's dislike of singling out specific groups for coercion, has been put forward as an argument against both voluntarism and the equal exposure lottery. Some argue equally well that doctors have been among the least burdened groups by educational level. Those in the military receive special pay, practice their specialty and suffer fewer of the risks and discipline burdens associated with military life. [2] Statistics through 1964 indicate that by educational level, the medical school graduate has been 'burdened' -- that is, has a higher military participation rate -- only in relation to nonmedical graduate students. [3] The nonmedical graduate student has, in general, pyramided student deferment to graduate school, thence dependency or occupational deferment, until no longer subject to induction. However, the medical

graduates' military participation rate is declining more slowly than that for other groups, and can be expected to do so until medical school output expands proportionately. The congress may view a high military participation rate as a price the profession pays for restricting supply into the profession. [4]

In the absence of selective conscription or draft induced military service, the human behavior problems associated with recruiting and retaining military medical professionals fall generally into two broad categories familiar to most everyone: income reward (incentive), and professional (occupational) reward (satisfaction).

Military doctors already are paid appreciably more than most other officers near the same age and of the same rank. But surveys have continuously shown that doctors have a higher per capita income than any other professional group in the United States. [5] Career military doctors continue to earn less than their civilian contemporaries and thus, despite earning more than their military line officer contemporaries, are making financial sacrifice by remaining on active duty beyond their obligated service. Doctors inherently feel that more lucrative incomes should be a natural follow-on to longer years of expensive academic preparation and austere initial professional qualification. The Gates Commission on an All-Volunteer Force [6] recommended a "new medical pay plan" which would increase a medical officer's total salary to $22,000 by his sixth year of service, with

annual or bi-annual increases thereafter to $39,955 for a Colonel (0-6) with 22 years service. The sixth year figure and a subsequent proposal [7] suggest inclusion, in this service computation, of the five years constructive time granted a new medical officer, by substantially increasing his salary after one year of active duty internship.

Professional job satisfaction is a broad area worthy of separate treatment; only highlights will be noted here. Military doctors feel, in varying degrees, that they lack certain opportunities more available to their civilian contemporaries. Among these are the availability of, or opportunity for; postgraduate/postdoctoral academic endeavors; technological and research endeavors; and medical school hospital faculty and administrative staff assignments. Many career military doctors desire to pursue and remain in clinical practice and medical specialties while advancing independently in seniority. This is contrary to career expectations in the military, for as medical career patterns are now structured, senior medical officers will channel into administrative and management jobs.

B. THE PROPOSED SOLUTION

In February 1971 the Office of the Assistant Secretary of Defense for Health and Environment, OASD (H&E), revealed a ten-point program of proposals designed to allow for future elimination of the doctor draft law provision, to improve the attractiveness of military careers for health care personnel, and, not incidentally, to provide better health care services for active-duty and retired personnel and their dependents. The following is a brief description of each of the proposals in the program. [8]

(1) A new competitive compensation plan for all military medical health professionals.... to increment military pay sufficiently to make such pay competitive with pay scales in the civilian economy. This point essentially proposes implementation of the Gates Commission recommendation (or a reasonable modification thereof), and would extend the "competitive salary schedule" to all other military health care professionals -- for whom the commission recommended "similar but somewhat less severe" pay increases.

(2) Establishment of a Uniformed Services University of the Health Sciences. This proposal has been advocated by the House Armed Services Committee Chairman, F. Edward Hebert, who first suggested a "Federal Medical School, similar in pattern of operation to the Military Academies" in 1949. [9] He formalized and reintroduced the idea into the 92nd congress in the form of H.R. 2, a bill "to establish a Uniformed Services University of the Health

Sciences" in Washington, D.C., and a provision for DOD to study the feasibility of establishing up to four similar or like institutions in other locations of major military hospitals. This add-on provision was thought to be in anticipation of likely negotiation with the senate in conference. As some OASD (H&E) officials put it, enactment of the University bill will allow the Armed Services to become producers of doctors, rather than consumers only.

(3) An increased number of flag and general officer billets for military medical professionals -- not to the expense of other billets, but over and above the current legal (and so-called 'Stennis ruling') limitations on total flag and general officer ceilings. OASD (H&E) officials reason that some star-rank billets should be created for highly skilled physicians (such as particularly qualified researchers and surgeons) who prefer to remain in technical or clinical practice rather than shift to medical command and management billets.

(4) An increase in the medical scholarship program. In 1971 the DOD was authorized a total of 458 scholarships and proposed an initial increase to 1800 - 75% to be allocated for physicians, and 25% for dentists. The program would provide later increases in steps to 5000 scholarships -- 4,000 for physicians and dentists and 1,000 for other health fields.

(5) An independent military research and development budget -- in the form of separate line budget items for

clinical investigation. All present military medical research money comes under the overall jurisdiction of the Director of Defense Research and Engineering. H&E officials believe the Defense Department should train its own medical investigators, and to do this, should fund a program big enough and challenging enough to permit retention of more medical investigators and researchers.

(6) Personalized career planning -- This is a goal which military health care professionals share with all other military specialist groups, and with all service personnel. The lack of opportunity to participate in a member's own career development, and the 'indifference of career management personnel' toward long range development of an individual officer's career, have been cited in the past as important factors contributing to the inability of the Medical Corps to retain officers on active duty.

(7) An improved promotion system for Medical Corps officers -- This has been accomplished in part. Medical Corps promotion quotas no longer come under overall Line quotas, as previously, but are established as a separate entity (except for flag and general officer ranks). In addition, the vast majority of Medical Corps promotions are now judged under 'fully qualified' rather than 'best qualified' standards.

(8) A reduction in payback time for special training -- This, too, already has been accomplished. Until recently, a doctor serving residency training as a military internist

or thoracic surgeon, for example, had to serve on active duty for several years beyond the two years' obligation required for other MDs. This requirement resulted in a shortage of applicants for many much needed resident training billets. The system was changed to provide a standard two-year payback, and there since has been a surplus of applicants in numerous specialties.

(9) A liberalized continuation pay program -- The original continuation pay program, established in 1968, permitted a physician with over eight years active service to receive a three-month bonus for each year of active duty for which he agreed to extend, and gave a four-month bonus to each physician with over twenty years of service for each year he agreed to extend. In 1970 the program was liberalized to permit a qualified specialist who has completed his initial active-duty tour to get a four-month bonus after five years of service as a medical officer, and to give credit for civilian specialty training in computing a doctor's active service as a medical officer.

(10) Establishment of a medical command system -- The command relationships between the various military Medical Corps and Service Line components can only be described as disorganized, according to OASD (H&E). H&E officials believe it would make more sense to establish a medical command system which would have jurisdiction over all of a service's medical units and facilities in a given area.

The last six program points can be implemented (notwithstanding opposition on certain specific points) administratively, in whole or in part, by the Department of Defense and appropriate components, without further legislative action. Personalized career planning, an improved promotion system, reduction in payback time for special training and liberalization of continuation pay have already been affected with satisfying results. It is as yet too early to make a final determination as to the effectiveness of the continuation program, but initial indications are that it is becoming more beneficial in retaining critical skill specialists on active duty.

Establishment of an independent medical research and development budget and a separate medical command system are proposals typifying an on-going rivalry among military line and specialists groups. These items are likely to continue to receive significant opposition from all interested elements other than medical.

The other program points, (1) through (4), require additional authorization and/or appropriation legislative action. Increased compensation continues to receive considerable mention as 'necessary' to 'essential' in various plans and amounts of increase from $10,000 to $16,300 annually. [10] This item is no doubt receiving quiet but firm opposition from other elements; other component officer specialists such as lawyers already feel discriminated against, as well as line officers who are concerned over the

widening gap between their pay and medical pay. Advocacy for increased compensation comes primarily from OASD (H&E) officials and component Surgeon Generals, while other elements,including congress, appear willing to await a more definitive determination of continuation pay effectiveness.

Major provisions of congressman Hebert's bill for increasing medical scholarships and establishing an armed forces medical school received substantial opposition in the Senate. [11] A conference version of the bill was passed by both houses in September, '72. The bill provides for up to 5000 scholarships at civilian medical schools, providing student's tuition plus $400 monthly, and that each student will serve a year on active duty as a medical officer for each year of scholarship aid. Some medical school programs now run as long as six years. The bill also authorizes a Uniformed University of the Health Sciences in the Washington D.C. area. It is to produce no fewer than 100 physicians a year within 10 years, and will use existing facilities at Walter Reed, Bethesda, and Andrews AFB hospitals. Students at the University will receive the full pay and allowances of the first officer pay-grade (0-1) and serve seven years on active duty after graduation. The cost of the first 10 years has been estimated at $102 million but the senate committee members have expressed feelings that the cost is understated.

A provision to lift the limitation on promotions of medical officers to general and flag rank was deleted from

the compromise version of the bill. This program proposal will likely continue to receive substantial opposition.

III. THE ISSUES IN NATIONAL PUBLIC POLICY

A. THE NUMBER OF PHYSICIANS

1. Background

The problem defined in Part II is but a manifestation -- a symptom -- of a more serious problem within the socio-economic, political and academic segments of our national public policy. The proposed solution, likewise, is but a treatment of this symptom -- a short range plan for temporary relief -- within the capabilities of one department of government operations.

It does not appear that professional medical personnel supply problems can be reasonably solved within a voluntary demand-and-supply framework for a number of years, and without significant changes in our public, institutional and government attitudes on a national scale. Why the supply of doctors has not adjusted to demand needs has been readily explained by past observers. Friedman and Kuznets noted in 1954 that entrance into the profession was being blocked.[12] In 1967 Dr. Rashi Fein observed that "Medicine is one of the few fields in which supply is restricted at the point of entry into the educational system rather than into the profession." [13]

The problem is an outgrowth of constructive beginnings; the creation of a permanent Countil on Medical Education by the American Medical Association in 1904, and the

publication in 1910 of Abraham Flexner's comprehensive study of the standards and quality of professional training in American medical schools. In Flexner's opinion, of the 131 medical schools in the United States in 1910, fewer than 40 supplied "the distinctly better quality of medical training." [14]

American medical school enrollments declined from a high point of approximately 28 thousand in 1904 to less than 14 thousand in 1920. The training legally required of medical practitioners has been systematically extended since the beginning of the century from three or four years of professional education preceded by two years of high school, to six or seven years preceded by graduation from high school. The legal requirements for premedical education generally match the requirements that medical schools must impose in order to be approved by the Council on Medical Education. The actual level of premedical education is maintained higher than that required by medical schools, or by law, by the 'selection' method of accepting applicants -- a method which might be considered a 'creaming policy'.

The number of applicants accepted by medical schools began increasing again in the 1920s. The percentage of applicants accepted fluctuated from 64.2 percent in 1926 to 51.5 percent in 1929 and climbed again to 62.2 percent in 1933. [15] In that year came one of the first explicit warnings on restricting entry into the profession. Harold

Rypins, then secretary of the New York State Board of Medical Examiners, stated:

> "Too many (people) are still unaware that American medical schools are definitely committed to a policy of restricting the number of their students. In all the professions there has developed in the last few years, an aristocratic, or at least a restrictive movement which, in a sense, is reminiscent of the medieval guilds. The trend is still in an early stage, but in law, medicine, dentistry and other professions under control of state licensure, the signs are apparent ... Without intention or design, the far-reaching steps taken by the physicians to raise educational standards during the past twenty-five years has resulted in limiting the number of students. Now, realizing the advantages of this unplanned restriction, leaders ... are taking definite steps to cut down the professional class." [16]

A search of the literature over the next few years following 1933, shows this statement to be representative of the opinion of medical leaders, whether in condemnation or justification of the policy. [17]

Seemingly unimpressed by these early expressions, the Council on Medical Education issued, in 1934 (and published in 1935), a warning "against the admission of larger classes than can properly be accommodated or than can reasonably be expected to satisfy approved scholastic standards;" they continued with the comment that "seven

schools have definitely stated that their enrollment will be decreased and others have indicated adherence to the Council's principles." [18] In each of the five years prior to 1934 for which data are available, with the possible exception of 1929, there was an increase in the number of applicants accepted by approved U.S. medical schools. [19] Each of the six years from 1934 through 1939 showed a successive decrease from the previous year. In 1938 the percentage of applicants accepted reached a post World War II low of 51.3 percent. More recently the percentage of applicants accepted have been as shown in Table I.

TABLE I

Selected Medical School Applicant Acceptance Percentages [20]

Year	Number of Schools	Total Number of Students	Percentage of New Applicants Accepted
1961	86	30,288	59.4%
1966	88	32,835	48.2%
1971	103	40,238	45.3%
1972	108	43,650	37.0%
1973	114	47,259	NA

One observer explains the rising number of applicants and students both accepted and rejected thusly:

> "....physicians' salaries have become embarrassingly high ($40,550 median in 1969, according to Medical Economics), causing even the AMA to admit that we could use more doctors. The relative income advantage of doctors over other professions (law, engineering, dentistry)

has grown wider and wider -- no doubt one reason why the number of applicants to medical schools with advanced degrees in other fields increased from 552 in 1970 to 1,896 in 1972. The rising percentage of rejected applicants has created pressure to let a few more in. According to Mrs. W. F. Dube of the Association of American Medical Colleges, 'Every week we get phone calls from people who are successful lawyers and engineers who want to switch to medicine.'" [21]

For additional explanation of the absolute numbers since 1968, see section IV B.

The traditional measure of the number of physicians is the physician-population ratio: number of physicians per 100,000 population. Proponents of our past medical education policies and defenders of the status quo often point to the relative stability of the ratio since its inception. Some have found the concept of the ratio more confusing than helpful. Tables II through V are samples of existing physician-population ratio statistics.

TABLE II

Physicians per 100,000 Population in the United States

Year	Table IIA Ratios*	Table IIB Ratios**	
		Total	In Private Practice
1900	157	-	-
1910	146	-	-
1921	134	-	-
1931	126	-	-
1942	134	-	-
1949	135	-	-
1950	134	151	109
1955	132	152	101
1959	133	-	-
1960	-	151	98
1962	136	-	-
1963	-	152	97
1965	-	156	97

NOT Available

- -

* Source: U.S. Public Health Service, Health Manpower Source Book, Sec. 9, 1959, p. 9, and ibid., Sec. 14, 1962, p. 3; cited in Fein, op. cit., p. 66. Table IIA ratios do not include Doctors of Osteopathy (D.O.) but do include non-practicing M.D.s -- retired, teaching, etc.

** Source: Data from U.S. Public Health Service, Health Resources Statistics: Health Manpower, 1965, no. 1509, p. 100; and U.S. Bureau of the Census, Current Population Reports, series p-25, no. 353, 18 Nov. 1966; cited in Fein, op. cit., p. 68. Table IIB ratios include D.O.s and non-practicing M.D.s and D.O.s. Figures for 1965 include certain identified graduates of foreign medical schools.

TABLE III

Physicians per 100,000 Population by Regions: 1965*

Region	Ratio
Mid-Atlantic	171
New England	168
Pacific	157
E. North Central	120
South Atlantic	116
Mountain	115
W. North Central	114
W. South Central	101
E. South Central	89

* Source: U. S. Public Health Service, Health Manpower Perspective: 1967, Washington D.C., 1967, p. 14.

TABLE IV

Nonfederal Physicians per 100,000 Population by Selected States: 1965*

State	Ratio
New York State	217
Mississippi	74
Alaska	71
District of Columbia	373
U.S. Mean	145
U.S. Median	120

* Source: U. S. Public Health Service, Health Resources Statistics, 1965, p. 101.

TABLE V

Nonfederal Physicians (M.D.s) per 100,000 Population by Area: 1963*

Area	Total Active	Active in Private Practice		
		Total	General Practice	Full Time Specialty
United States	125	91	35	56
Metropolitan-Adjacent	136	98	35	63
Greater Metro.	173	118	38	80
Lesser Metro.	125	92	30	62
Adjacent to Metro.	75	65	38	27
Isolated	75	65	38	27
Semirural	81	69	38	31
Rural	46	44	38	6

* Source: U. S. Public Health Service, Health Manpower Source Book, Sec. 18, Manpower in the 1960s, p. 25. The difference between total active and total active in private practice is accounted for by hospital staff, interns, residents, teaching, research, industry, etc.

Present day discussions based on the physician-population ratio have a tendency to become meaningless due to changes in the nature or medical practice and the environment of health care services over the preceding forty years. Physicians frequently emphasize that the rapid growth of urban areas and of transportation and hospital facilities has increased the number of patients a physician can care for effectively. Others point out that on the other hand, the advances in medical science have probably increased the

attention that must be devoted to the treatment of each patient, as well as the number of cases recognized as requiring medical attention. It can hardly be denied that the effect of specialization and group practice on medical services and health care delivery is not revealed by the simple ratio. William H. Stewart writes:

> "Specialization has completely altered the meaning of the physician-population ratio by which manpower needs have been measured for many years. We know that the gross ratio has remained fairly constant in recent years. We do not really know what the ratio means."[22]

2. The Social and Moral Issues

The organization of medical education in the United States permits close control over the admission practices and standards of the individual medical schools. Friedman and Kuznets noted in 1954 that in all but three states, either legal requirements or the rules of the Boards of Examiners [23] specify that among individuals studying in this country or in Canada, only graduates of medical schools approved by the Council on Medical Education and Hospitals of the American Medical Association, may take the examination for admission to practice. Thus through the approval process, the Council on Medical Education has almost complete control over the number of medical schools. In addition, the Council has direct contact with and influence over each school through its accrediting activities. [24]

From 1900 to 1964, while the population climbed 152%, real per capita income 208%, bachelor degrees 1,730%, and graduate degrees approximately 5000%, medical and dental school output edged up only 34% and 40% respectively. In recent years the United States has imported approximately 18% of its new licenteates, primarily to fill institutional internship and residency vacancies. Dr. Fein estimated in 1967 that medical service demand will grow 1.8 times faster than the population; this is slightly greater than the supply of the medical services projected growth rate and is expected to widen rather than narrow past shortages. [25]

The rationale most often advanced in support of controlling entry into the medical profession is maintenance of quality physicians. Interesting, as well as morally disturbing, is the fact that the percentage of applicants previously refused medical school entry who are subsequently accepted, is only slightly lower than the percentage of first applicants accepted. [26] Certainly those reapplying after initial rejection are fewer and likely possess better premedical qualifications, and the time lapsing between the first refusal and later acceptance may have been spent in additional training - which is precisely what one would expect from a creaming process. Nevertheless, it seems reasonable that the supply of innate ability is sufficient to furnish each year more medical students than are admitted to medical schools. It must also be remembered that a small but significant percentage of applicants (7% estimated)

rejected by approved American schools, apply and enter the few unapproved schools or foreign schools, and are later licensed or otherwise certified to practice in the United States.

Arguments of quality versus quantity often dissipate into undeterminable subjective judgements of the difference between good quality and high(est) quality. Some data in general seem to indicate that the relationship between quality of performance as a physician and the traditional measure of quality of an applicant for admission to medical school is much more tenuous than was previously assumed. The data indicated that physicians performing at a lower level of competency had a less comprehensive group of clinical skills. This, however, did not seem to correlate with the quality of the institution in which they were educated or trained, or the undergraduate record which the student had compiled. [27] Other reports indicate that:

- Better medical students tend to become better physicians.
- One is more likely to be a better physician if he has had more internal medicine experience.
- There seems to be little or no relationship between academic performance and family or community background, nor was the medical college aptitude test of significant predictive value.
- It appears on the average that the better medical student performs at a higher level of proficiency for

a few years after entering practice, but that this effect disappears around the age of thirty-five. [28]

The question of trade-off between quality and quantity has seemingly not been approached in an unqualified manner. The traditional answer has not embraced the need for trade-offs and has usually taken the form "what is needed are more physicians of the highest quality", [29] rather than, what is needed are more qualified physicians.

The moral issue relates to the question of the right of qualified students to pursue studies in the fields that interest them. The essence of this is that, even if professional licensing arrangements are justified in order to assure quality, it is quite another matter to prevent students from pursuing medical education if they so desire and are qualified. This practice seemingly violates the concepts of a non-discriminatory policy in educational opportunity, and of an individual's freedom of choice, a phrase held in high esteem by medical professionals after licensing. It is not clear that medicine should single itself out as a profession in which the number of students accepted is more a function of future "needs," as defined by the profession, than of the number of qualified persons who desire to study and practice.

B. THE ORGANIZATION OF HEALTH CARE PRODUCTIVITY AND DELIVERY

1. Solo (Individual) versus Group Practice

The physician's fee-for-service solo practice has long been the traditional form of organization for deriving medical care services in the United States. It has become the symbol and expression of the doctor's individual independence and professional freedom of choice. For three to four decades an increasing number of persons knowledgeable in the fields of medicine and economics have felt that an expansion of group practice would foster improvements in our system of health care and medical services. Medical oriented observers believe group practice would enhance the quality of care; economists view it as saving or improving the utilization of scarce resources; others feel that it would foster new financing mechanisms from which would stem desirable consequences for both patients and physicians, and for auxiliary health care personnel. The author has noted a consistent theme of 'well patient' or 'health maintenance' emphasis throughout descriptions of existing comprehensive group practice plans, particularly prepaid plans.

There is a spectrum of differing group practices. A group may consist of two or three specialists with adjoining offices and sharing the services and costs of ancillary personnel and equipment. A clearer contrast of solo and group practice may be perceived, however, if we define a group practice as an association of physicians of different specialties, working together at one location and sharing

financial arrangements among themselves, and with their patients, according to some prearranged plan, to render as nearly complete services to their clients as possible. This arrangement can be referred to as a comprhensive group practice with fee-patients (standardized fee-for-service) or with prepaid group plan patients. It has been estimated that nine percent of all physicians in private practice are practicing in groups, [30] but that only six percent are in comprehensive group practice. [31]

The advantages and disadvantages of group practice have been discussed by numerous observers. The following are among the advantages most often noted: [32]

(1) If sick people are to receive good care, they must see more than one physician. Group practice provides an efficient form of organization.

(2) Group practice keeps a physician alert since other physicians observe and sometimes participate.

(3) Consultation with other physicians of the same or differing specialties is easier and more efficient.

(4) Additional expensive equipment is more easily obtained and more economically employed.

(5) The physician does not have direct financial dealings with the patient. Medical judgements and decisions are not influenced by financial considerations.

(6) Group practice permits the physician to concentrate on those things which he feels best qualified to do -- yet provides convenient access to other specialists.

(7) Group practice has the potential of raising the quality of care since it permits each physician to more readily schedule time off for postgraduate courses, special studies, conferences and so forth.

On the other hand the following disadvantages of group practice are often argued:

(1) The above advantages seem true in theory but not in practice.

(2) The individual practitioner can handle most medical needs. The extra physicians and equipment add unnecessary costs.

(3) The group practice physician does not "grow" since he is supervised and not "on his own". Furthermore, he is cut off from the larger medical community.

(4) In most places it is easy to obtain consultation. The individual physician, therefore, need not be limited to consultation only with the specialists in a group.

(5) The patient does not feel that he has his "own" physician, nor can he choose to see a specialist outside the group.

(6) Many inadequately trained physicians who would not succeed in solo practice, join groups.

The advantages and disadvantages cited are numerous though not exhaustive; some more significant, some less so. Some may apply to one or more groups but need not apply to group practice in general. It is noteworthy that many of the criticisms of group practice involve physician-physician

and patient-physician relationships rather than health care and medical service productivity matters. Such relationships are most certainly important, but the prevailing attitudes on these matters need not be assumed unchangeable. It seems reasonable that these attitudes can change if group practice were to grow in size and influence so that both patients and physicians were better acquainted with the concept and practice. For instance, in actual health care systems in other countries and comprehensive prepaid group plans in the United States and Canada, the members are encouraged to select one personal family physician as their primary source of medical care and contact point for access to the rest of the system or plan.

Other criticisms, such as the use of inadequately trained specialists, are not basic criticisms of group practice. Even if the charge were true, it is not an inherent characteristic of group practice that poorly trained physicians must be used. Furthermore, the alternative would be solo practice by these same poorly trained physicians. It is quite likely that, from the public's point of view, such physicians should practice in groups (where a measure of control and a further learning process is possible) rather than in solo practice.

The advantages cited in favor of group practice seem far more compelling than do the arguments against this organizational form. Some of these potential benefits relate to

economic considerations, others to the relationship of the specialist to other physicians and to the patient. [33]

In economics it is often found that larger organizational units are able to achieve economies that are denied to those of smaller size. These "economies of scale" result from the fact that certain divisions of labor and specialization are made possible and justified when the number of units produced -- or services rendered -- is sufficiently large. Furthermore, various types of equipment and kinds of personnel are only available in whole units. We cannot buy half a machine or employ half a person. Thus such equipment and personnel are used more efficiently in larger-size production units. Therefore, as the scale of operations increases, economies arise in part as the result of the possibilities for a greater division of labor, more extensive specialization and use of special equipment and personnel. As economies of scale exist in other sectors of the economy, so do they exist in medical care, for example, in hospitals. We may also expect that they would be present in group practice as contrasted with solo practices.

Since medical care involves other personnel and capital equipment as well as the physician, it is unlikely that the optimal combination of factors is to be found in the office of the solo practitioner. For that to be the case these factors -- physician, nurse, equipment -- would be utilized in whole unit relationships to each other, for example, one physician, two nurses, one x-ray machine. This

is not likely and even less so if the practice is more general and the equipment (and personnel) required more varied, yet more infrequently used. Should the optimum ratio of nurses to physicians prove to be 1.6, for example, the solo practitioner would depart farther from the optimum than three physicians practicing in a group with five nurses, or ten physicians employing seventeen nurses. Nor is it likely that the appropriate ratio is one x-ray machine per general practitioner or pediatrician.

This inflexibility in solo practice may have various consequences. Some or all of them may exist in varying degrees. Physicians may do without some equipment or personnel which would be useful. Thus the physician is operating at lower productivity than would otherwise be the case, perhaps rendering less service, perhaps rendering a lower quality of service. Alternatively, physicians may purchase more equipment or employ more personnel than is needed. The equipment or personnel may then stand idle for periods of time because "it is better to have too much rather than too little." This results in an inflation of costs of medical care since all patients will share in paying for the inefficiency. This is not meant to imply that payment should be made only by those who use certain parts of the capital investment. The principle that all patients pay for the x-ray machine even though only some need it, seems desirable, however the point here is that it would be less inflationary if all patients paid for one machine that operated at

capacity, rather than for two machines, each operating at fifty percent capacity. On the other hand, the availability of underutilized resources (equipment and personnel) may, unconsciously or by design, induce unnecessary use of the resources (overdoctoring) to help pay for them. One way to justify high prices to the consumer is to render more (even if unnecessary) services. In the field of health care and medical services the consumer is woefully ill-equipped to judge whether services are necessary or helpful.

The more efficient use of personnel would also enable a saving of physicians' time. In a group practice situation -- with consequent division of labor -- physicians would be freed to carry on those tasks for which, by virtue of their training and experience, they are uniquely qualified. If physicians are providing services that do not require the special skills of a physician, group practice can provide an organizational framework which makes it easier to accomplish those services with ancillary personnel. This new division of labor would thus bring benefits on the manpower side since, in enabling the physician more effectively to limit his practice to matters and procedures which require his particular qualifications, the effective supply of physicians' services would be increased. After his studies, Russel V. Lee stated:

> "Perhaps one of the greatest advantages of group practice lies in its ability to use a large number of paramedical personnel who spare the doctor many hours

of time and bring the patients benefits ordinarily unavailable....This has great economic advantage in freeing the physician for purely professional activity." [34]

The absence of a sufficient number of detailed studies and comparisons of group and solo practice makes it difficult to assess the full dimensions of the potential health care, medical service and economic benefits of group practice. While there are a number of group practices in the United States, the data they have generated have been used chiefly for management control purposes and have not been sufficiently subjected to critical evaluation. With limited analysis and with inadequate measure of quality, it is not clear whether the results obtained apply to the particular group practice examined or whether they could be generalized.

A 1960 survey of group practice in Canada, found that the use of ancillary personnel was greater -- yet the net income of physicians was higher -- in group practice (due to increased productivity), than in solo practice. [35]

A detailed study has been made which compares the experience of families insured under two comprehensive group plans in New York City: The Health Insurance Plan of Greater New York (HIP) and Group Health Insurance, Inc. (GHI). HIP is a prepaid plan and GHI pays on a fee-for-service basis. The study found that: [36]

- GHI enrollees had a higher hospital admission rate (11 percent) annually than HIP enrollees (6.3 percent). They (GHI) also stayed in the hospital more days.

- GHI subscribers had a higher utilization of surgical procedures both in and out of hospitals.

- The physician visit rate (excluding surgical and obstetric visits) in home, office and hospital was about the same for goth groups.

In a study of the Federal Employees Health Benefit Program (FEHBP), it was found that the number of non-maternity hospital days per 100 patients was 86 for those covered by Blue Cross-Blue Shield, 77 for those enrolled in indemnity plans, and only 43 for those enrolled in group practice plans. [37]

Another study of the FEHBP for 1966, found that 98 of every 1,000 Blue Cross-Blue Shield patients were hospitalized, compared to 46 of every 1,000 prepaid group members. Blue Cross-Blue Shield patients spent 876 days in the hospital, compared to 408 for the group members. There were 73 operations per 1,000 Blue Cross-Blue Shield subscribers, and 31 per 1,000 among group practice members. [38]

The trend in these figures might be attributed to:

- Overutilization in fee-for-service plans;

- Underutilization in prepaid group plans;

or one of the above combined with the contention that prepaid group practice is health maintenance or well-patient oriented, and therefore requires less utilization. Following his study, George N. Monsma, Jr. wrote:

"Finally it was concluded that the differences in surgical rates seem to be caused at least in part, by

overutilization in the insured fee-for-service situation rather than by underutilization in the salaried group practice situation." [39]

Recent and current literature contain conflicting references to prohibitions against group practice or prepaid group practice:

- "The influence of the medical lobby has helped to write prohibitions or restrictions on Prepaid Group Practice into the statute books of more than half of our states." [40]

- "I was surprised to learn of the power of medical societies in maintaining laws in twenty-two states which restrict physicians from forming new types of group practice to compete with older forms of solo practice." [41]

- "This is why the AMA has pressured seventeen states into out-lawing such plans, and has been prosecuted under antitrust laws for trying to kill prepaid plans in other states." [42]

A study of state legislation in 1969 found that in less than half the states was the situation sufficiently defined to enable prepaid consumer-sponsored group practices to be developed without concern about possible legal restraints. In some states, the law requires a majority of the board of directors of such plans to consist of physicians, and in some there are requirements that all physicians in an area have the privilege of joining the plan should they so desire. Other restrictions hinge on

organizational and fiscal requirements of the plans, including questions of limited liability, tax and insurance. [43]

2. The Hospital System

The literature indicates that, at least as early as the post World War II planning period, there was remarkable agreement with respect to the central role of the general hospital in modern medical care.

The four basic functions of the envisioned general hospital were summarized by the Commission on Hospital Care in 1947; the hospital is a workshop for the physician; it is an educational center; it is a center for medical research; it is a center for community health, including prevention of disease, care of ambulatory patients and home care. [44] In August 1948, the journal, Modern Hospital, devoted a special issue to "The Hospital of the Future", to which leading hospital administrators, physicians, and architects contributed. Their major theme, as they looked fifty years ahead, can be summed up in the words of Dr. E. L. Crosby, later the director of the American Hospital Association:

> "The greatest change will be the metamorphosis of the hospital from a diagnostic and curative headquarters into a community health center, with all (that) this entails. The outpatient department will be at least of equal importance with inpatient facilities."

All agreed that group practice would be the major pattern for outpatient as well as inpatient care.

In 1952 the President's Commission on the Health needs of the Nation said:

> "Hospitals are at the heart of our modern medical system....More and more, (the modern hospital) is becoming responsible for a continuing flow of health services to the community, supplying preventive services in health centers at one end of the line and rehabilitative and home care services at the other end." [45]

To date, however, few general hospitals have been equipped or philosophically oriented toward the fulfillment of anything like these advanced but aging concepts. Most are still primarily concerned with the treatment of short-term acute illnesses. Preventive medicine, ambulatory care, the problems of the chronically ill, research and health education are clearly secondary in priority. Advancements in the traditional area of inpatient care are overshadowed by the soaring costs of elaborateness, overutilization of beds (admissions), underutilization of duplicated sophisticated equipment and services. This has proved a bitter disappointment to many hospital administrators who hoped to see the general hospital develop more rapidly toward the physical and organizational synthesis of the major aspects of medical care -- prevention, diagnosis, treatment and rehabilitation. We are still faced with the question of whether the hospital should be the doctor's workshop or the Community's health center. Idealistically a hospital should be both -- a synthesis between these major concepts,

and between the major groups responsible for the complex and wide-ranging objectives of the hospital -- trustees and administrators, and the physicians and medical staff.

There is a sharp dichotomy in hospital organization. [46] The roots of this conflict between health care personnel and management apparently go back to eighteenth century Britain and the establishment of the Anglo-American tradition of voluntary hospitals. There was no such dichotomy in medieval days when hospitals were operated, with little medical assistance, by monastic orders for the sick poor. There is apparently no such duality in the major European hospitals which are usually run by full-time chiefs-of-medical-services, with complete authority. The distinguishing feature of the Anglo-American voluntary hospital, however, has been its use by private physicians for private patients with little or no accompanying administrative or financial responsibility. In return, the doctor normally donated care for the hospitalized indigent who constituted the majority of the hospital population.

Recent developments -- the hospital's increases in size, complexity, utilization, cost, and its greatly altered financial base -- have intensified the inherent instability of this administrative structure. Health insurance, public medical care programs, and the new patterns of hospital utilization have transformed the large majority of admissions into paying patients. The growing public investment in hospital construction and operation and the emergence of

private and public health insurance plans, both tend to enlarge the role of the hospital as a community-service organization. The indigent patients, those who bother to seek medical aid, are paid for at least in part by public funds, but their treatment is being increasingly relegated to sparse public emergency rooms and clinics.

The hospital has become an indispensable workshop for the modern physician who finds it virtually impossible to practice medicine without hospital affiliation. The hospital is the center of his professional world, and he is acknowledged to be its key figure. A considerable amount of the private physician's income is earned in the hospital. Quite naturally he wants the institution equipped with the latest scientific and technological facilities. But the doctor's relationship to the hospital is ambiguous. As a rule he assumes neither administrative nor financial responsibility, yet, in practice, his is the most influential voice in the organization. He admits and discharges patients; he alone can diagnose, prescribe, and treat patients. With his high professional status, he may, in many hospitals, countermand administrative orders and ignore authority. The result is the confusing duality that prevails today throughout the hospital system.

There may be internal problems as well. Within the hospital the administrator finds that part of his personnel are involved in conflicting lines of authority to him and to the medical staff; and the trustees may find themselves at

odds with staff doctors over whom they have only tenuous authority.

The problem of hospital organization goes to the heart of the problem of medical care organization in general; the necessity for reconciling large-scale organization and large-scale financing with the continuing need for highly individualized services. [47]

It is sometimes proposed that hiring the entire medical staff and director on a salary or contract basis would increase the physicians' sense of responsibility for hospital administration and operation, and help clarify lines of accountability. This is a distasteful prospect to many doctors but, as yet, they have failed to accompany their objections with any positive or constructive alternatives of their own. It seems clear that most have no interest in participating in the financial and operational responsibility for the hospitals.

The complete staff-director concept has been demonstrated at a few hospitals, such as the Henry Ford in Detroit and the Cleveland Clinic Hospital,with significant success in integrating the professional and administrative structures, and without compromising or restricting professional integrity. Most of the profession, however, seems vigorously opposed to such practice, alleging "hospital domination" or "lay control" or invoking the "corporate practice of medicine" argument. When viewed within the concept of full-time medical directors and chief-of-services, however,

the controversy seems not so much that of lay control as that of persuading the physician to modify his independent entrepreneurial role in favor of responsible administration, management and institutional teamwork.

The duality conflict in hospital organizational relationship leads to other costly and detrimental influences. The American Hospital Association Guide Issue includes a multiple set of separate standards of approval to which hospitals are subject -- including, but not limited to: accreditation by the Joint Commission on Hospital Accreditation; medical school affiliation; residency and internship programs approved by the AMA; approved nursing schools or programs; AMA specialty boards approval; cancer program approval by the American College of Surgeons; etc. In such a climate, it is hardly surprising that the hospital system has become a virtual arena for numerous organizational conflicts.

The most quoted (and likely valid) answer to why hospitals costs are out-pacing every other form of inflation, is the belated catch-up in sub-standard wages for hospital employees. Labor represents more than half of a hospital's costs and their employees were long among the country's most underpaid groups. By unionization and collective bargaining, and aided by minimum wage requirements, they have improved their income standards considerably.

The other most significant reason for the ballooning cost of hospital care is the exceptionally expensive array of

new medical facilities and hardware and the highly trained personnel necessary for operation. During the 1950s, hospitals were independently busy acquiring clinical laboratories, electrocardiographs, blood banks, radioactive isotope therapy facilities, and ever increasing capabilities to perform lengthening batteries of laboratory and x-ray tests. More recently the drive has been for kidney dialysis units, tumor institutes, open-heart surgery units and teams, and additional radiation therapy facilities -- all tremendously expensive hardware requiring highly paid personnel -- with much duplication and underutilization -- and all paid for by spreading the costs among each and every patient.

An open-heart surgery unit generally requires a skilled team of twelve doctors, nurses and technicians maintained on constant stand-by. It is estimated that over 800 American hospitals maintain these units as a high prestiege item. To function efficiently, a team should be regularly doing one operation a week. It has been estimated that in possibly a third of these hospitals, as much as a year may pass without a single operation being performed. [48]

A major contributing factor to the inflation of hospital costs has been the greater willingness of health insurance to pay for hospital bills rather than for physician's fees and outpatient services, combined with an excess of hospital beds. And when the health insurance business finally extended coverage to include some outpatient care, and the government tightened up on Medicare and Medicaid

abuses, this produced a worsening situation. Hospitals were left with 20 to 25 percent of their beds empty in a period when hospital construction was accelerating, thereby adding to the demand for and bidding up the price of physicians' services. The excess supply of hospital beds does not -- as we normally think of it in other industries -- drive prices down, but up, because a high fixed overhead is divided among fewer patients.

This situation has prompted some few individual states to pass laws which permit them to:

- Forbid both the construction of new hospitals and the expansion of those already built.
- Force disclosure, for the first time, of contracts under which some doctors (e.g., pathologists, radiologists, anesthesiologists) have customarily received hundreds of thousands of dollars a year for specialized services performed in hospitals.
- Approve hospital rates before they go into effect and reject rates deemed to be excessive.
- Compel a group of hospitals in one area to pool facilities to avoid duplication of, for example, expensive cancer treatment equipment.
- Install on state boards and councils dealing with health care a majority of consumer representatives, (an idea that would have been considered revolutionary only a few years ago).

From a national perspective such actions by the states produce fragmented results, but at least there is a widening recognition of the problem. Since 1964, New York has blocked construction of some 48,000 unnecessary beds in general hospitals and 37,000 beds in long-term care facilities. Converted to dollars, it is estimated that $1.3 billion in capital expenditures has been saved, plus $600 million yearly in operating costs. [49]

In a 1972 report, the General Accounting Office analyzed the need for hospital beds in Baltimore, Cincinnati, Denver, Jacksonville, Florida, San Francisco and Seattle. The report concluded that the cities collectively would have 4,228 more beds than would be needed by 1975. This number may seem modest, but the Atlanta Regional Commission, which coordinates a seven-county area around the city, estimates that it is overbedded by 2,000 units at a cost to the area of more than $28 million a year.

Eighty percent of new hospital starts now are profit making hospitals (although ten years ago it was the other way around). Physicians are owning stock in the corporations that build and operate these new private hospitals and they tend to refer patients to these hospitals. But it's good business sense not to send the indigent patients, so they (more frequently) refer those with money. People who are less affluent are referred to the nonprofit hospitals. The result is that the private, profit making hospitals, skim off the cream of the paying patients, leaving the non-profit

hospitals with fewer and less affluent patients to assume an increasing share of the fixed high overhead costs. [50] This trend has spurred twenty-two states to clamp down on hospital construction with certification-of-need laws.

The voluminous and labyrinthine statistics of health care costs can be sorted and selected to support almost any thesis desired. A central theme throughout, however, seems to bear out the theory that hospitals charge as much as the traffic will bear, and that the number of physicians is sufficiently small that they can locate where the money is. [51] Dr. Charles Lewis, of Harvard's Center for Community Health, conducted a study which indicated that the need for medical treatment mysteriously seems to rise to meet the available capacity. Dr. Lewis states it this way:

> "Parkinson's Law applies in the medical care system as it now exists. The number of beds available in a community determines the extent of hospitalization. The number of surgeons available determines the frequency of operations performed. The amount of money available for insurance coverage determines the amount of money spent for medical care." [52]

C. HEALTH CARE FINANCING

1. Private (Voluntary) Health Insurance

Political debate over health care has historically centered on methods of paying the increasing costs of modern medicine. The AMA's mid-century (1949-52) national campaign lobbied successfully against plans for a federal health insurance system for all age groups. The campaign cost $4,678,000 and resulted in what has been expressed as 'a landmark in the annuls of public relations' (but not in health care development). [53] Thereafter, only moderate effort was required to sustain the campaign and stop consideration of national health insurance, stigmatized as socialistic and for its anticipated "crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care." [54]

The demand for government sponsored health insurance within the organized labor movement became less urgent with the growth of voluntary health insurance through collective bargaining. Enrollment in private insurance for hospital bills (first priority) rose from 32 million people in 1945 to 105 million in 1955, and to 175 million people in 1969 (88 percent of the civilian population). In 1957, private health insurance premiums were valued at nearly $6 billion; by 1967 they were near $17 billion, of which over $10 billion flowed through commercial (profit) companies, and the balance through the nonprofit Blue Cross (hospital bills), Blue Shield (medical bills) and lesser plans. [55]

Efforts during the Eisenhower administration were concentrated on building on the apparent success of private health insurance. Health financing proposals of this period were designed to recognize a public-private mix of funds, with the public funds reserved as far as possible for the poor. Private health insurance companies were envisioned as being the third-party payer of medical bills for the middle class, while the existing system of federal grants to the states would provide medical care for those on public assistance. Thus, ideally, most of the population would have at least some of their health expenses covered. Federal grants to states for payment to hospitals, doctors and other providers of medical care for health services given to public assistance recipients were $51.3 million in fiscal year 1949-50. With the added increment of federal grants for vendor payments under the Social Security Administration, the federal share rose to $311.9 million in 1954-55 and to $492.7 million in 1959-60. [56]

Extending federal grants for public assistance recipients, however, does nothing to encourage the health insurance industry to address the real problem of providing reasonably comprehensive health insurance plans at an affordable price. During this period, a major flaw -- deficient coverage -- began to emerge from the impressive, but misleading, rise in private insurance enrollment figures. In a study of families spending $500 or more on health services in 1953, half had insurance coverage for less than

20 percent of their medical expenses. And taking expenditures as a whole, only 3 percent of the families with health care expenses could be reimbursed for as much as 80 percent of their bills. [57] Thus, a significant inadequacy in coverage was emerging and, indeed, according to Rosemary Stevens, "in no year yet (1971) have private health insurance plans managed to cover more than a third of the total medical bill of private patients." [58] As health care costs continued to inflate -- from an average expenditure of $84 per capita in 1950, to $149 in 1960 (and to $250 in 1967) [59] -- the spiraling pattern became increasingly clear: increased costs -- offset by an increase in premiums and decrease in coverage -- increased out-of-pocket expenditure, for both insurance and medical bills, consuming an ever increasing proportion of incomes, and particularly low and fixed incomes. By 1960 the plight of the poor and aged was again recognized sufficiently to foster passage of the Kerr-Mills Act, a temporary holding point until the passage of Medicare and Medicaid in 1965.

The fallacies and deficiencies of private health insurance are inherent and seem self-sustaining. It is becoming increasingly clear that the health insurance industry cannot, of its own, provide an essentially social or public utility service. Insurance as a business depends on a realistic balance between premium income and benefit expenditures, estimated on the basis of actuarial risk. On this basis, the healthier person is the better 'risk' for

health insurance, as he is for life insurance, or as the man with a safe driving record is for automobile insurance. A social service, on the other hand, should be designed to provide services for all, including those who need them most -- in this context, the highest insurance 'risk'. It is not intended to portray the health insurance industry as made up solely of individual private insurance plans. Millions of Americans are covered by group plans negotiated by large employers and/or unions. Those fortunate enough to have access to a group plan are covered for whatever the plan covers and usually at a reasonable cost to the employee. [60] In some states private group plans are available but the costs are usually prohibitive with respect to lower-middle and lesser income families. As costs continue to increase, many of these plans become fraught with coverage gaps or exclusions, and most are of only marginal value in 'catastrophic' illnesses. According to a 1973 study by Cancer Care, Inc. and the National Cancer Foundation, Inc., a catastrophic illness can reduce a middle-income family to poverty in less than two years. The study indicated that the average cost of such an illness was $21,718; eighty-four percent of the families reported costs exceeding $10,000, and thirty percent had expenses between $25,000 and $50,000. Only thirty-nine percent received medical or health insurance payments in excess of $10,000. [61]

The health insurance industry has no capability to control the costs of health care. This fact in turn renders

the industry incapable of influencing improvements in health care organizational and operational efficiency or quality of care. Even though they have met with little success, the non-profit Blue Cross-Blue Shield plans have occasionally tried to institute firmer cost controls. Most insurers, however, seem content to simply raise premiums (and/or reduce coverage) to cover charges as they climb relentlessly higher. [62] The Blue Cross-Blue Shield efforts have failed because the medical professions effectively control the managing boards of these plans. Hospital representatives are a majority or near majority on the boards of all seventy-five Blue Cross plans across the country. Even the Blue Cross trademark, an asset in selling insurance, has been owned for years by the American Hospital Association and is granted by them to insurance carriers. The situation with the Blue Shield plans is similar. The Blue Shield boards are dominated by physicians and the plans must be approved by the appropriate medical societies. The fee schedules and administration of Shield plans are proposed by either the medical society or a committee on which physicians constitute a majority, and are then approved by physician-dominated boards. The medical professions essentially control the plans in return for their participation. Indeed, the Blue Cross-Blue Shield arrangements, as most voluntary health insurance plans, seem better designed to protect the interests of the providers of health care than to protect the patient-users. [63]

Competition is usually a force that leads us to expect better products or services at the same or less cost. Competition in the health insurance industry is not directed towards these ends, however, for the industry cannot offer better care at competitive prices, nor can it influence physicians and hospitals in this direction. Thus this industry's competition is vested in marketing techniques which result in such schemes as 'experience rating'. By limiting a health insurance plan to people in a 'safer' or low-risk group, the insurer can offer the same plan at a lower premium; premiums can be lower because the company's experience indicates that it will pay fewer benefits to this group. But the lower premium isn't offered because the group will receive health care at a lower cost; it is offered because the group has been singled out as low-risk on a statistical basis. As premiums go down for low-risk groups, they increase for everyone else. The net result is exclusion of more and more people by ineffective coverage or prohibitive cost and, indeed, these are the very people most in need of health insurance.

Another inherent disadvantage of voluntary health insurance is the insurer's retention of funds for 'overhead' (high salaries, advertising costs, sales commissions, general and administrative expenses) and corporate profits. In 1969 the industry retained 49.2 percent of the premiums from individual policies. For the country as a whole, both group and private policies, the commercial carriers kept 17 percent of all premiums paid to them. [64] These figures and the

controversy itself have changed little over the past twenty years. Findings of a committee commissioned by the senate to study voluntary plans showed that retention charges for Blue Cross in 1949 were 15 percent; Blue Shield, 21 percent; and that commercial companies retained 20 percent of the premiums for group insurance and 45 percent of the individual policy premiums. [65]

Excepting comprehensive prepaid group plans, the vast majority of all health insurance plans are still tied to the fee-for-service principle that pays each provider for each service to each patient. It is this principle that tends to allow each physician and each hospital to set themselves up as independent businesses, with no definitive budgetary constraints, and with little incentive to organize with other physicians and hospitals to offer more comprehensive, better-organized and improved care. Private health insurers do not seem mentally prepared or physically capable of violating this principle so sacred to the medical profession -- and so historically detrimental to the public.

2. Medicare and Medicaid

Experiences with Medicare and Medicaid have shown that the development of payment systems for health care is politically as well as socially important. The argument is a familiar one. If physicians and hospitals respond to demands for adequate and efficient health services without direct government controls or incentives, then only health insurance is necessary. If, on the other hand, the health

care providers seem unable to respond with more effective services, even to the increased demand generated through more generous insurance benefits, then direct government action may prove socially desirable and politically necessary. It is here -- in the response of a largely private health service system to massive infusions of public funds -- that the experiences of Medicare and Medicaid have proven so important.

The federal government took over no hospitals or other facilities, nor does it directly employ any doctors under Medicare. The same is true with respect to the state governments under Medicaid. The new system was thus not socialized medicine in the sense of creating a nationalized, governmental service. As third-party reimbursement plans, both Medicare and Medicaid imitated the private insurance system. Physicians continue to practice as they did before. They accept Medicare patients into their private offices or in hospitals and the billing mechanisms are similar to those for other, nongovernment, types of health insurance. The doctors merely fill in a different form from that usually requested for patients covered by private health insurance, and continue to be paid on a fee-for-service basis.

The real significance in Medicare lay not in the doctor's office, nor in the hospital, but in the administrative structure set up between the federal government and the health providers. The legislation broke down medical services into two separately-administered sectors, those connected

with hospital care and those primarily concerned with physician services. Under Medicare part A (hospital insurance), groups of hospitals, clinics and extended care facilities (nursing homes) are able either to deal directly with the Social Security Administration for their payments, or to nominate an organization (subject to government approval) to act as a 'fiscal intermediary'. The functions of the fiscal intermediary as defined in the law include: reimbursing providers for their services; providing consultative services to hospitals and other participating agencies to help them set up the appropriate records systems; establishing channels of communication and information for providers of care and the Secretary of Health, Education, and Welfare; and auditing records. [66] The fiscal intermediary accepted functions which would otherwise have had to be established by vastly expanding the Social Security Administration's district offices.

The use of private fiscal agents rather than government regional or district offices was logical in that the latter had no experience in handling hospital and medical claims. But the result of the legislation was to entrench Medicare firmly into the structures of private health insurance. The great majority of hospitals (6,876 of 7,906) nominated the Blue Cross Association as their intermediary through their membership in the American Hospital Association. Over half of the clinics and extended care facilities also selected the Blue Cross Association; the remainder selected

commercial insurance companies; a few facilities chose to deal directly with the government. As a result, the seventy-five local Blue Cross plans, together with twelve other principle private intermediaries, became agents of a major government health program.

A similar pattern was followed for Medicare part B (medical insurance), although the private insurance agents were termed 'carriers' rather than intermediaries, and the choice was made not by the providers of care but by the Secretary of Health, Education, and Welfare. The majority (33 of 49) of the part B carriers so designated are Blue Shield plans. Each carrier covers a particular geographical area, usually a state. Part B carriers are responsible for making payments for physician and other services from the national supplementary medical insurance trust fund which, in turn, draws its income from monthly contributions from those sixty-five and over, and from the government. This channeling of public funds through the private sector was one of the major features of the new two-part Medicare program and it became one of its major headaches in terms of oversight and regulation.

In terms of provider acceptance, however, the program was an immediate success. Medicare itself, once passed, was rapidly absorbed into the physician's accepted and environmental structure of office and hospital, based as it was on

preexisting insurance patterns and on the payment of physicians according to their fees in private practice.

The amount and the method of paying for physician services are crucial questions in the establishment and effective operation of any government sponsored system of health financing. By adopting the system of private intermediaries and carriers, Medicare avoided long discussions and potential confrontations with physician organizations on standard methods and amounts of reimbursement for services. Instead of a national professional group or local groups negotiating over fee scales, capitation fees or contracts with the Social Security Administration, open-ended responsibility was delegated to the participating private insurance organizations to pay fees which seemed reasonable. Instead of a public organization setting the relative value of an office visit to a physician, the prevailing fee customs remained. Fee setting itself rested on the integrity of the medical profession and, indeed, in about 96 percent of cases, Medicare has paid the fees charged by physicians. [67]

The intermediaries and carriers also welcomed the arrangements. The board chairman of the National Association of Blue Shield Plans, a practicing physician, commended the framers of the bill in 1965 for their "keen understanding" of the role of voluntary health insurance organizations in the implementation of the Medicare program, for recognition of Medicare part B as the antithesis of socialized medicine, and for allowing the aged population to continue in accustomed

patterns of payment. [68] For the government and the public, these arrangements would provide a direct challenge to the effectiveness of the private insurance sector as a vehicle for national medical insurance, and to physicians as controllers of medical services.

The impact of Medicare on individual physicians was not one of federal control but of increased professional flexibility. Physicians were now free to see elderly patients without concern that the patients would be impoverished by submitting to treatment, or that their own services would go unremunerated. The value of such services to the patients is inestimable in terms of the effect of the services themselves, and the reduction in anxiety of people faced with the threat of an extended and expensive illness. But there were two related impacts of the system on the responsibility and behavior patterns of physicians. One was that under Medicare a group of persons who had been poor in their ability to purchase medical services suddenly became comparatively affluent. The other lay in the responsibility of organized groups of physicians to review the appropriateness of fees on behalf of fiscal intermediaries.

Medicare had been introduced to protect the incomes of the elderly. But since physicians were encouraged through the new system to charge for care of the elderly on the same basis as they charged other more prosperous members of the population, Medicare, supported by developing Medicaid programs for the poor, evened up the financial status of the

population. And a by-product of Medicare was to support and increase the incomes of physicians. By 1970, part B of Medicare, 90 percent of which is for physician services to the elderly, was paying out amounts which averaged $7,000 per physician. [69]

Fee review was left largely to the carriers, just as hospital reimbursement, which was on the similar basis of "reasonable costs," was left to the part A intermediaries. The Social Security Administration has shown reluctance to pressure the carriers to standardize the concept of usual and customary fees; the crucial cost decisions remain in the private sector, with the government acting as a reimbursement agency.

The idea of customary charges was thus translated (subject to review by carriers for obvious abuses), in the absence of effective controls, into the individual actions of 300,000 physicians and became the key to developing the costs of Medicare. This was true not only in the case of physician fees but also in the determination of hospital and nursing home utilization and in the prescription of diagnostic tests, drugs, and other services (part A). Instead of the development of relatively independent and effective local agencies for the administration of Medicare, with strong physician participation and leadership, Medicare evolved swiftly into an additional source of cost coverage and income to medical providers; and then in turn to congressional and public anxiety about the apparent lack of administrative responsibility for an increasingly expensive medical program.

Physician fees increased from an annual average of 3 percent between 1956 and 1965 to an apparent rise of 6.5 percent between June 1965 and June 1967. [70] In part to meet the rising expenditures the monthly premium paid by the elderly for services under part B of Medicare was increased from the original $3 in 1966, to $4 as of April 1968, and again to $5.30 in July 1970; these sums in each case being matched from general federal revenues. Including the first $50 which a patient pays for care under part B, the person sixty-five years or over had to pay $113.60 a year (1970) before receiving any services, compared with $86 in 1966.

A list of all payments made to physicians of $25,000 or more under Medicare was compiled by the Social Security Administration for the Senate Finance Committee, with the amounts attributed to account numbers (not physicians' names). There were 4,284 such physicians in 1968, excluding those known to be in group practice. Of these, eighteen received $150,000 or more from Medicare, in one instance for treating fewer than 350 beneficiaries. [71] Such figures were produced together with other testimony indicating abuse of Medicare (so-called gang visits when a doctor would sweep through a nursing home and charge Medicare for a visit to each patient) and the development of higher fees under Medicare than under the carrier's own Blue Shield plans. [72] A small but significant minority of physicians was clearly abusing Medicare. Moreover the private carriers, which were officially the government's agents, appeared to be doing

little to correct abuses, and in many respects were themselves inefficient and wasteful. The tone of the Finance Committee hearings and staff report was one of shock and of the need for a much more forceful role by the federal government in administering Medicare.

The focus on cost controls by the Congress was an inevitable reaction to a large governmental program which constantly overran its budget estimates. For example, the estimate made in 1965 for part A costs in 1970 was 3.1 billion; this was steadily revised upward to $5.8 billion in 1970; part B costs, meanwhile, doubled between 1967 and 1971. [73] Costs themselves, however, are only one element in a complex system for health services. Local and national public medical review committees (had congress legislated them into existence) would presumably have been expected to evaluate the performance of the system in efficiently meeting the needs of the beneficiaries. For hospitals and extended care facilities (under part A), the Medicare legislation required "utilization review" procedures as a condition of participation -- that is, a review of the use of the hospital (or nursing home) and hospital services by individual medical patients. Each institution had to establish a utilization review committee which was supposed to consider both the medical necessity of services and the use of health facilities.

The requirement and establishment of utilization review committees was not the same, however, as putting them

into effective operation. As yet, few efforts have been made to push for their development as crucial evaluating agencies in the operation of Medicare. Instead of welcoming the opportunity to review the effectiveness of services, there has been local physician resistance to committee influence over the individual's prerogatives to practice medicine. A survey of hospitals by the Social Security Administration in 1968 found that almost half of the hospitals were not reviewing any admissions, although this is a statutory requirement; [74] mechanisms for extended care facilities were even less developed. Part A intermediaries have thus been reluctant (as have their part B counterparts) to exercise meaningful control in matters involving their traditional relationships with health care providers.

An important and concurrent aspect of developments in Medicare, has been the rapid rise and fall in expectations of Medicaid. Medicaid was set up as a program of federal grants to states for the expansion and consolidation of existing scattered programs for vendor payments for medical care on behalf of persons on public assistance, and for those who were not on assistance but whose financial situation could not withstand major medical expenses. The latter had been termed medically indigent in the Kerr-Mills program for the aged, established in 1960. The problems described in the administration of Medicare concurrently beset the Medicaid program. Federal payments to the states for medical assistance increased from $555 million in fiscal year 1965 (before

the impact of Medicaid) to $2.8 billion in 1970, with parallel increases by state and local governments. [75] In an atmosphere of growing public and congressional concern over the costs of Medicare and Medicaid, the Senate Finance Committee held hearings in 1967. The committee chairman, Sen. Russell Long, reiterated his concern in further hearings in 1969:

> "We want the Medicaid program to provide help to people who need it and we want the Medicare program to look after the medical needs of our senior citizens. We want that care to be of high quality. But, we think it should be provided on a basis that is efficient and economical, not on a basis which is wasteful and extravagant." [76]

The Medicare program is a landmark in that, while limited both in population coverage and benefits, it established a system of compulsory national health insurance for the first time in our history. A significant by-product of Medicare is that it brought us nearer to the realization that something more fundamental in our national health care system must be altered. That something is the "free-enterprise" safeguard clause which congress, in deference to organized medicine, wrote into the Medicare law, forbidding the government to "exercise any supervision or control over the practice of medicine, or the manner in which medical services are provided." This clause rendered Titles XVIII (Medicare) and XIX (Medicaid) as virtually open-ended commitments to finance medical services for the aged and

poor, from both Social Security contributions and general tax money, with no safeguard for the public. Enshrined in the law were the aged principles of paying "reasonable costs" rather than fixed prices, to hospitals, and "reasonable" or "customary fees," rather than standardized fees, to physicians; and to do so through an existing inadequate and indifferent private health insurance structure (Medicare) and through state and local welfare mechanisms (Medicaid).

3. The Federal Health Bureaucracy

The time seems long passed in the United States when it could be debated whether or not there should be federal government intervention in health care and services. Government involvement in the development of health care personnel and facilities, educational institutions, payment plans for selected population groups, and medical research is substantial and important to our national well-being. Under the impact of Medicare, Medicaid, and other medical related legislation of the 1960s, federal expenditures on medical programs grew from $2.9 billion in 1959-60, to $15.1 billion in 1968-69, and to $20.6 billion in 1970-71. Aggregating all public expenditures, federal, state and local, the amount represents more than one-third of the national total expenditures on medical care and health facilities. [77]

One might expect that federal expenditures of this magnitude -- ten percent of all federal outlays -- should be accomplished by careful planning, programming, budgeting and control. Such is not the case for two traditional and

somewhat related reasons. The first is the stigma of 'socialized medicine' attached to overt federal controls in the health care field, so carefully cultured and propagandized over the years by medical societies, associations and related lobby groups. The other is the public's perceived role of the federal government in common welfare spending. Until recently the typical federal assistance program, whether for land grant colleges, highways, vocational training, crippled children services, or vendor medical payments under public assistance, did not involve an expressly defined national purpose -- that is, there was not the recently introduced program or objective approach to planning and budgeting. Federal programs were designed to support state or local efforts, financed through formula and other grants, with federal advice but not control. Medicaid is an example of the influence of this assistance philosophy; it was designed to aid the states rather than to establish a federal health care program for the medically indigent. Another clear example of this attitude is the establishment of neighborhood health centers. Whereas we recognize the dire need of ghetto minorities for access to both preventive and curative care, the government provides these centers by authorizing grants for proposed Community Action Programs under the Economic Opportunity Act of 1964 (P.L. 88-452). The action programs are ostensibly designed for job training and other aspects of community development but provide a convenient and acceptable device for providing health care.

A direct result of the historically weak federal role has been the diffusion of health subsidies over a patchwork of legislation dealing with federal health assistance and service programs. Elements of federal action are now scattered across 221 different government agencies and departments. The largest of these is the Department of Health, Education, and Welfare (DHEW) which has responsibility for over 70 percent of the federal health dollar, including Medicare, Medicaid, and most of the recent health programs of the 1960s. But even within DHEW there are major divisions, fragmentations, rivalry and overlap resulting from an attitude of passive federal administration, and of the development of health services around a variety of social welfare programs. The Assistant Secretary for Health and Scientific Affairs, the highest-ranking spokesman on health within the government, is connected only with the divisions carried over from the old United States Public Health Service. As a result he is the responsible executive for only 22 percent of the DHEW health budget. Medicare, as a part of Social Security legislation, is operated by the Social Security Administration, and Medicaid, a public assistance program, by the separate Social and Rehabilitation Service, which also administers a number of maternal and child health services. Each program is administered in its own sphere of operations, in the context of its own piece of legislation and its own congressional overview committee.

Lack of coordination among federal departments and offices is compounded by a lack of clear delineations in their span of operations. The nature and number of programs mean that there are constant problems of overlapping functions and jurisdictions. Despite the coordination of various pieces of legislation in the Health Manpower Act of 1968, as many as 14 separate federal departments and agencies are engaged in administering programs for health training and education. [78] Dr. James Shannon, former director of the National Institutes of Health, estimated that in the Johnson administration alone, Congress enacted 51 pieces of health related legislation, administered through 400 different authorities. [79] Some of the problems of overlap emerge in quite evident ways. The Small Business Administration and the Hill-Burton program (in DHEW) have in some instances made grants or loans to competing hospitals in the same communities, with a resulting over-expansion of hospital beds and duplication of facilities. [80]

Congressional committee hearings and staff reports are increasingly bearing out a near crisis of administrative chaos. The combined effect of one piece of legislation after another, poured into an uncoordinated health service system, has been to produce a growing dysfunction in the operation of our federal health establishment. Government 'grantsmanship' and 'subsidy-mania' through the private sector and state and local mechanisms maintains a 'low profile' role of federal participation but results in uncoordinated assistance

programs proliferating without sense or direction. The present situation is one of a need for a national policy, objective, and program for health care (and for science, urban planning, welfare, etc.) which will maintain sufficient decentralization of services to enable utilization, while providing at the same time centralized planning, direction, standards and control.

IV. TRENDS (ALTERNATIVES) FOR THE FUTURE

A. HEALTH CARE IN OTHER INDUSTRIALIZED WESTERN COUNTRIES

As the time for debating federal government involvement in health care is past, so is it likely that the historical thesis that our health care problems will be solved in the 'market place' is increasingly anachronous. Although health care providers often display individual entrepreneurial characteristics, medical professionals and institutions, collectively, appear a classic example of a discriminating monopoly; a monopoly that varies prices according to income or demand in order to get the most revenue from the largest number of people. [81] The market place philosophy has consistently been the position of the profession, the AMA and related interest groups, and our experiences have just as consistently belied it.

The inadequacies and inequities of our health care system have not evolved uniquely to the United States; all have been experienced before in other countries. It may be beneficial to our perceptions of the subject to note, in resume, a few basic facts about the organization of health care on a national basis in some of these countries. [82] For clarity it should first be stated that there are three basic methods of paying physicians in national plans, sometimes used in combination with each other:

Fee-for-Service - a fee for each procedure, sometimes paid by the patient subject to reimbursement, sometimes paid by the government or an intermediary.

Capitation - a fixed annual payment for every person on a doctor's list of patients (subscribers), regardless of how often the patient sees his doctor. A variation is 'case payment', a fixed sum paid only for persons who become ill (receive care).

Salary - a fixed payment to the doctor, based not on how many patients he sees, but on his professional rank and the amount of time he devotes to practice.

Great Britain - National Health Insurance is administered by the Department of Health and Social Security. Eighty-five percent of the cost is borne by the Government, with contributions by workers and employers. It covers all residents, plus most visitors. Physicians operating on a panel system, receive a fixed schedule of fees from National Health Service for special services. General practitioners are reimbursed on a capitation basis. The National Health Service runs a system of national hospitals, directly administered by the Department of Health, with their personnel, including doctors, on salary. Health centers, clinics, and extended-care facilities are operated by county councils.

The National Health Service, in effect since 1948, entitles everyone in the British Isles to health care, financed principally by the Government. A general practitioner receives a capitation payment of about $2.50 a year for every

patient registered with him, regardless of how much treatment he gives the patient. Ninety-seven percent of British residents are registered with National Health Service doctors, though they are free to see doctors privately outside the national system. They are also free to choose their doctors, although, in practice, they tend to register with the doctors most conveniently available to home or place of work. The physician usually operates from his own office and with his own staff. He is encouraged by extra pay incentives, to work with groups of physicians, but he is not compelled to do so. The British doctor is rewarded for doing things which are considered socially useful. He gets extra pay for treating a person over sixty-five, for making night calls, for treating transients, for providing maternity care, for giving preventive care and for moving to a remote area short of physicians.

Because of British tradition rather than because of National Health Service, once the patient goes to the hospital he is out of the hands of his family doctor. In the nationalized hospital, the system is different. The independent physician paid by capitation is replaced by a fully salaried staff in publicly operated institutions, all integrated within a single system and with easy transfer from one to the other for specialized services.

France - The national health insurance fund operates under the general supervision of the Ministry of Social Affairs. Management control is exercised through sixteen

regional Social Security Fund offices which have authority to negotiate hospital and medical fee schedules with regional professional associations. All wage and salary earners, farmers, craftsmen, self-employed and retired persons, are covered. Aliens working in France are entitled to the same benefits as citizens.

All doctors participate in the program. The rates of payment are fixed on a fee-for-service basis by agreement between the Social Security Administration and the medical associations. All public hospitals and a number of private institutions approved by the Social Security Administration participate. Health insurance covers seventy-five percent of outpatient medical and dental bills, eighty percent of medical fees, laboratory tests and hospitalization, and seventy-five percent of most pharmaceutical prescriptions.

West Germany - Health insurance is under the general supervision of the Ministry of Labor and Social Affairs and is administered through state insurance offices. There are about 2,000 local, occupational, and other funds, managed by elected representatives of insured persons and employers and organized into state and national federations. It is compulsory for all wage and salary workers below a certain earnings level to be enrolled in a health fund, not necessarily a public one.

Doctors are associated with individual funds and are paid by them on a fee-for-service basis. The most common criterion for payment is a nationwide fee schedule, arrived

at by the social security carriers and the organization of insurance doctors, and subject to approval of the Ministry. Hospitals are maintained by public authorities (state and local governments, universities, and insurance institutions), and by private organizations (churches, trade unions, and private owners [in the case of sanitariums]), with national subsidies available.

Eighty-five percent of the West German population is covered by the compulsory system (all workers whose income falls below a certain minimum, most pensioners, and many self-employed persons). The well-to-do take care of themselves, and the unemployed rely on charity. The system is administered through some 2,000 sick funds, organized by locality or by factory. (There are also sixteen special funds which offer greater benefits for those who want to travel first-class by paying higher contributions.) Employers and employees share the premiums equally. The patient is free to choose his doctor, and the doctor may not make any charge to the patient (except when the patient insists on some procedure which the doctor considers medically unnecessary and therefore unchargeable to insurance). Drugs require only a small nominal charge per prescription to discourage over-utilization. It is a fee-for-service system, based on a voluminous schedule of fees for specific services. (It includes, for example, what the doctor may charge for a telephone conversation with his patient.) The role of the Government is to establish the minimum coverage, the maximum

premiums (currently eleven percent of wages), and maximum fees. The rest is basically left to negotiation between the insurance doctors and the insurance funds. This system, in which the doctors' association itself handles the distribution of the money and sets individual fees after negotiating lump-sum contracts with the insurance funds, is unique. The doctors have an incentive to police their own colleagues because they are all sharing a lump sum negotiated with the insurance fund and limited by the government ceiling on premiums.

West Germany's health-care program is concentrated in the doctor's office. There is little competition from hospital outpatient departments. Hospital doctors may see insurance cases during their off hours in the hospital, but only when referred by the private practitioner. A West German's insurance covers an unlimited stay in the hospital, which is generally run by the local government and has its own staff of salaried physicians.

Sweden - The medical insurance plan is supervised by the National Social Insurance Board under the general supervision of the Ministry of Social Affairs. Insurance is compulsory (children under sixteen are covered by their parents' insurance). Foreign workers and other foreign residents who are registered for census purposes are entitled to the same benefits as citizens. The National Board of Health and Welfare supervises the medical personnel, the hospitals,

and the pharmacies, and has direct control over the state mental hospitals, the state pharmaceutical laboratory, and the state institutions for forensic medicine. Most hospitals are owned and operated by public authorities, primarily at the county level. The regional social insurance offices pay seventy-five percent of the physician's services up to certain limits listed in published fee schedules approved by the Government after negotiation with the Swedish Medical Association. Individuals have a free choice among doctors.

Everyone sixteen and older, with an income exceeding a certain minimum, pays an annual insurance premium, based on his income and the area where he lives (to take into account variations in costs among regions). For this premium he and his dependents receive benefits amounting to seventy-five percent of the official fee for each medical procedure. The fee schedule is relatively short and simple as such schedules go. The patient pays the doctor, gets a receipt, and the regional insurance office reimburses him for seventy-five percent of it. This, it should be noted, is one of the least generous formulas in Europe, but it reflects the drastic shortage of physicians in Sweden and the desire to discourage overutilization. There has been such a scarcity of doctors in Sweden that physicians are booked far in advance. In practice, due to the competition for care, average reimbursement is substantially less than seventy-five percent. The doctors who practice privately (1,200 of the total of 9,200) set their own fees, but reimbursement is

still on the basis of the official fee. Thus, some patients get as little as fifty percent of their doctors' bills refunded.

Hospitalization, under the Swedish insurance system, is free in public wards, as are all needed surgery, medical treatment, laboratory and X-ray tests, and drugs. There are additional personally paid charges for patients who want semi-private or private rooms. There are also some surviving private hospitals, where the patient pays all costs, but so few are willing to do so that private hospitals now represent fewer than three percent of beds in Swedish general hospitals. As in Britain, when a patient goes to the hospital, he loses contact with his family doctor and comes under the care of a salaried hospital physician. This is more a product of tradition than of the insurance system. In fact, Swedish medical authorities, concerned about the results of this separation, have started rotating general practitioners through the hospitals to catch up with new techniques.

The Netherlands - A national health protection program was codified in 1966 as the Health Insurance Act. The act provides compulsory coverage for wage-earners, the aging, and the disabled, paid largely by employers through a 7.2 percent payroll tax. It is not a universal system. About half the population is insured compulsorily, and another twenty percent voluntarily. The remaining thirty percent -- including pricipally the rural population, the very poor, and the very rich -- must depend on their own resources, on voluntary insurance, or on charity.

For the 70 percent of the Dutch population who are covered, the program is administered under general regulations set by the government whereby local insurance plans contract with hospitals and physicians. Doctors are paid on a capitation basis -- each doctor receives a fixed annual amount for every person registered with him for care. The beneficiary chooses his own family doctor, but he can only see a specialist to whom he is referred by his doctor. His insurance covers hospital treatment up to one year per illness, plus drugs and a variety of other benefits, and dental care under some conditions.

Canada - Canada is included here, briefly, because it recently instituted a system of national health insurance, likely influenced by the highly successful Windsor Medical Services group plan, sponsored by the Essex County, Ontario, Medical Society. [83] Canadian health insurance operates under a joint federal-provincial system. The Department of National Health and Welfare shares costs and provides consultative services. The Federal Government provides about half of the medical insurance costs of the participating provinces. The basic aim of the provincial systems is universal coverage of all residents, with a waiting period for non-residents. Most public general hospitals have been approved for inclusion in the hospital insurance system. Selected private hospitals providing special and convalescent care have been approved for payment on a contract basis in most provinces. The method of paying physicians varies from province to province.

Communist Countries - For contrast, a few general words on the Communist system may be appropriate. This system, of course, is the outcome not of public consensus but of a dictatorial political party ideology. In the Communist bloc countries a Ministry of Health operates a network of hospitals and dispensaries. Physicians and other professionals are on salary, although they can supplement their incomes by private moonlighting. Health care is financed from the state budget, and patients pay only a share of drug costs. Patients are assigned to the nearest facilites (or they can, at their own expense, have recourse to the moonlighters).

For the salaried doctors, incentive payments are closely geared to the goals of the regime. For example, a bonus may be paid to a physician in an industrial location if absenteeism at the factory is low. This encourages prevention of illness; it also sometimes encourages doctored reports to underestimate the extent of illness. The doctors, a large number of them women, are relatively poorly paid -- often earning little more than skilled workers. Individual practice has virtually disappeared. It is not an ideal situation for doctors; it does, however, despite long waits, excessive paper work, and other inconveniences, serve the community. Some eighty percent of the 230 million Soviet citizens visit their polyclinics every year for free care and check-ups. Though unattractive, it may be likely that no other system would have worked as well in a country which started with such a shortage of medical resources. This may

help explain why the Soviet system tends to be emulated, at times, by under-developed countries in their early emergence stages.

This summary of systems in other countries is not intended to imply that any part of any other system might be appropriately imported to the United States. Each system is an outgrowth of its own national history, culture and unique experience. Nor is it intended to evaluate any system relative to any other; each has its own significant and peculiar problems and continues to undergo adjustment through the scrutiny of its public constituency. The essential point here is, that each of these systems (except the Communist experience) represents an instance where the existing health care system of a nation-state was designed, not in the market place, but in the arena of public policy.

Two recent quotations emerge as particularly germane to this discussion of public health care systems. In Sweden, where the political struggle for the present system was a vigorous and sometimes bitter one, Dr. Arne Ekengren, vice-president of the Swedish Medical Association, told an interviewer from Medical Economics:

> "Most doctors and virtually the entire population are now happy with the national health insurance program...We Swedes can be stubborn at times, and that includes physicians. However, we are not unreasonable people, and, after a while, we began to see the reason for national health

insurance. For example, one of the arguments against the program was that two-thirds of the population was covered by voluntary health insurance. However, we now know that the people who really needed full health coverage -- the poor and the people on the economic borderline between the poor and the fairly well-off -- didn't get it. Today they do." [84]

In order to observe some other nations' health care systems first hand, the Senate Health Subcommittee went on a two-week fact-finding mission to Europe and the Middle East in the summer of 1971. They visited Great Britain, Denmark, Sweden, and Israel; they talked at length with doctors, health officials, hospital administrators, insurance experts, teachers, students, government officials, and the citizens in general. The chairman of the subcommittee summarized his findings thusly:

"Most of us in America have been led to believe that health care is a disaster in Europe. We believe that the people in England and other countries cannot get health care and are unhappy with their systems. We believe that the people don't get to choose their doctors and that the government tells their doctors what to do. We believe that costs are out of control in Europe, worse than in America. We believe that the people are treated coldly by big organizations and have lost the doctor-patient relationship we've cherished in America.

"From what I saw, these things are simply false; they are myths that we have been taught by those who fear they will lose their high incomes or their freedom of choice if America were to change its health care system.

"The fact is, while most Americans are angry and frustrated about health care, most Englishmen, Danes, Swedes, and Israelis are not. The vast majority of citizens in the countries we visited describe their health care system with pride, and no major political party in these countries would dream of trying to repeal the system. Indeed, many of the people we talked to were horrified to learn that Americans have to worry about whether they can afford health care. The fact is also that while the federal government in America has fought organized medicine to pass such programs as Medicare and Medicaid, in Europe government and organized medicine have entered into a constructive partnership with which most physicians and hospitals are very satisfied." [85]

B. MILESTONE: THE CARNEGIE COMMISSION SPECIAL REPORT

The pattern of medical care in the United States ten or twenty years hence may not be one of federal domination of health care and services, in the sense of a monolithic or centralized governmental health service, as in Great Britain. Nevertheless, it should be recognized that the key to changing our present health care system is inevitably in the future actions of the federal government. The Medicare program stands as a landmark in the decade of the 1960s in that, though limited in scope, it placed the stamp of official recognition on the need for a system of national health insurance. Subsequent experiences with Medicare and with the Medicaid program are no less a part of that landmark.

We have started the 1970s with what must be considered at least a milestone in awareness, insight, and foresight concerning our present and future health care system: The Special Report and Recommendations by the Carnegie Commission on Higher Education. [86] The commission, recognizing an urgent need for early action in the field of health manpower education, issued a separate special report on this subject in October, 1970, two years ahead of its planned final report. The commission carefully considered the viewpoints of some observers who disputed the existence of a current or impending shortage of physicians. These observers argued that:

- The real problem is the maldistribution and inefficient use of physicians.

- The ratio of other health workers to doctors and dentists is increasing rapidly.
- The work of the health care team will soon be far more effectively coordinated than at present.
- Physician's associates and assistants, with less prolonged training than the fully certified doctor receives, will increasingly take over some of the physician's duties so that his time will be released for the use of his highest skills.

The commission recognized that some changes were occurring but concluded that: "there is no question, in our judgement, that an acute shortage exists," [87] and also: "The most serious shortages of professional personnel in any major occupation group in the United States are in the health services." [88]

Throughout the commission's report of reforms and goals to be achieved, and in its many recommendations, the primary theme is the need for expansion of health manpower education. The commission believes that medical entrant places can be expanded by as much as 38 to 44 percent in existing and developing institutions. Some of the recommendations are:

- Acceptance of enough qualified applicants to fill all entrant places.
- A 50 percent increase in medical school entrant places and a 20 percent increase in dental school entrant places by 1978-80.

- Reduction of medical school programs from four to three years between the B.A. and M.D. degrees by 1973-74. The estimated number of entrant places would be increased by an estimated 4,500 by 1976-77, a 31 percent increase. (Reduction of the academic program time involves the commission's recommendation to integrate the B.A. and M.D. curricula, and eliminate academic duplication in the preprofessional, professional and postgraduate programs.)
- Provide a degree between B.A. and M.D. degrees such as Bachelor of Medicine. Foster physician associate/assistant programs.
- Reduction of time between the B.A. degree and full practice from 8 to 6 years. (Reduce internship and residency from four years to three).
- Establish nine recommended new schools to provide 900 to 1,350 new entrant places.
- Development of approximately 126 area health education centers, affiliated with university health science centers by 1980.
- Expansion of the functions of university health science centers in coordinating health manpower education and in the development of improved health care delivery systems in their regions.
- Expansion of programs to increase manpower in all health care allied and related fields.

- Development of a voluntary national health service corps.
- A relatively low uniform national tuition policy for institutions providing medical and dental education.
- Establishing an Educational Opportunity Bank for medical and dental students.
- Appointment of a National Health Manpower Commission to make a thorough study of changing patterns of education and utilization of health manpower, with particular reference to new types of allied health workers, of changing patterns of health care delivery, and of the feasibility of national licensing requirements for all health manpower.

Taken as a whole, the commission's report seemingly rejects the sometimes posed theory that the effective use of physician manpower depends primarily on a taut supply of physicians.

The commission quietly makes another observation which, if implemented, may prove to be the most innovative change in American medical education and health care delivery in over sixty years. The commission notes that the Flexner model, based on the German medical education system with emphasis on biological research, has been the sole accepted model in the United States since 1910. Although it has led to great strides forward in quality of research and individual practitioners, the Flexner, or research model, looks inward to science in the medical school itself. It is a

self-contained approach and consequently, has two weaknesses in modern times: (1) it largely ignores health care delivery outside the medical school and its own hospital, and (2) it sets science in the medical school apart from science on the general campus with a resulting duplication of effort. The commission believes future efforts should be devoted to promoting greater integration of medical education and the nation's social needs. It writes favorably of two new models presently emerging:

> (1) The health care delivery model, where the medical school, in addition to training, does research in health care delivery, advises local hospitals and health authorities, works with community colleges and comprehensive colleges on the training of allied health personnel, carries on continuing education for health personnel, and generally orients itself to external service.
>
> (2) The integrated science model, where most all of the basic science (and social science) instruction is carried on within the main campus (or other general campuses) and not duplicated in the medical school, which provides mainly clinical instruction. In this model (as in England), the medical school may be essentially a teaching hospital; but this is not necessary -- it may, rather, carry on all its 'Flexner' functions except the traditional first one or two years of science education. [89]

Although the commission is primarily concerned with higher education, and their report emphasizes the importance

of increased federal financing of health manpower education, they also observe that:

- The federal government already supports most of the costs of medical research. [90]
- The federal government collects about two-thirds of all tax revenues and is in a position to rely much more heavily on.... taxes than is feasible for state and local governments.... and is in a much better position to increase its expenditures on public services. [91]
- A national health service corps should be developed to bring improved health care service to low income and rural areas of the nation. [92]
- Gradually, we are likely to shift toward a situation in which health care is a public utility; and, the government's role in protecting the health of the population will inevitably become broader in scope. [93]
- As a result of the Medicare and Medicaid programs, the federal government is now far more heavily involved in the financing of health care than ever before; these programs are inefficient and excessively expensive in that they only cover high-cost, high-risk groups; and that, the great advantage of a comprehensive national insurance system would be the inclusion of all the good risks along with the poor risks, resulting in much lower average costs. [94]

- Health care is coming to be regarded not only as a necessity but also as a right to which all persons are entitled; the trend toward ensuring the right to health care is virtually certain to continue until all Americans are guaranteed access to adequate care without regard to means; and that, increasingly, experts predict that the United States will adopt a national health insurance system, perhaps within the decade of the '70's. [95]

A final highlight of the commission's report is the revelation of ostensible changes in long-standing policies of two of the most influential medical professional associations. During the commission's studies the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) issued two joint statements [96] calling for rapid expansion of medical school entrant places. These statements additionally, though in general terms, embrace other immediate steps and longer-range goals detailed in the commission's report and recommendations. The commission was apparently impressed with the significant import of these policy statements and included them as Appendix A. to their special report.

C. NATIONAL HEALTH INSURANCE

The recent impetus for a system of national health insurance creates a corresponding need for a practical explanation of this concept. Historically, the movement first enjoyed discernable support during the progressive era of 1908-18, as a logical next step after enactment of workmen's compensation legislation. It was next considered in parallel with the Social Security Act and other social legislation of the 1930s, and became a full blown national issue from 1946-52.

Debate and consideration of the concept has been traditionally confused by a shroud of socio-political emotionalism. Medical professional groups and societies, with quiet but firm support from the drug and insurance industries, have invoked the spectre of "socialized medicine" over most of the health care legislation which they have opposed. This use of loose and ambiguous terminology stands in sharp contrast to the medical establishment's insistence on precise clarity of language in drafting legislation. [97] A socialized medical system would place the government in direct authority over four areas of medical care in addition to existing public health operations, namely: production of health care personnel; provision of medical facilities; organization, administration and delivery of all health care services; and payment of all medical expenses. The medical care system within the armed forces is analogous to such a system. A compulsory health insurance system concentrates

on the payment area and a soundly financed one places the government in the position of insurer, but it falls far short of a strictly socialized system.

The government spends an estimated $7 billion annually for purely socialized systems for the armed forces and veterans, hospitalization for the tuberculous, the mentally ill or retarded, and medical services for Indians. Other aspects of American health care have increasingly been near-socialized in the areas of public health, medical education and training, facilities, and through federal grant and subsidy systems for the expenses of medically indigent groups. But the emotion-laden charge of "socialized medicine" is raised to influence public attention away from the payment aspect because a system of direct public funding of medical expenses implies public responsibility, accountability, standards and controls.

A simple definition of a national health insurance plan could be, a system whereby the federal government would become the health insurance carrier for the nation; or a system wherein the government would provide identical insurance coverage to all citizens for essential health care; or a system wherein the government would issue a group health insurance plan in which every citizen was a member. To be made precise, any such definition then has to be qualified according to the degree or extent of coverages -- service benefits, monetary benefits, population group -- designed into the plan. There are two basic approaches to

designing health insurance plans, health service benefits or cash indemnity benefits; and these reflect basic differences in the philosophy of health insurance. The service benefit approach is based on the conviction that in the event of illness, the individual's need is for medical care rather than for cash to help him purchase care. Service benefits assure protection to the individual and eliminates the financial barrier to the use of services specified in the plan. On the other hand, the cash indemnity approach reflects the application of traditional insurance principles to provide protection against the costs of medical care. It sets a monetary limit on the benefits for which the individual will be reimbursed and contributes payment toward the cost of services covered in the plan.

There are two distinguishing features which identify a service benefits plan. One is the participating physician -- the physician who agrees to accept obligations in accordance with the provisions of the plan. The other is the specified upper limit of income; for subscribers within the limit no extra billing is permitted and the fee schedule provides full protection for the services included in the plan. The more common cash indemnity plan lacks these features; while there may be a fee schedule, there is no agreement between physicians and the plan concerning either the fees or the income level below which the fees might constitute full payment for services. Under such circumstances 'extra billing' is the prerogative of the doctor; and the patient, regardless

of income, does not know his degree of protection until he needs (and receives) a service included in the plan.

The difference between service and cash benefit plans is, in reality, not so clearly defined except for the extremes described. A service plan acquires the characteristics of a cash indemnity plan when a significant percentage of practicing physicians are non-participating -- have not agreed to the plan. The plan subscribers who receive services from these physicians may be subjected to extra billing even though their incomes are below the specified limit. Similarly, a service plan tends to become a cash plan when the upper limit of the subscribers income is specified so low that the majority of subscribers do not receive service benefits. Hence, for most of the insured, the plan is a cash indemnity policy since, beyond the stated income limit, extra billing is permitted and the patient does not learn the extent of his protection until he acquires medical services. It is also conceivable that a cash plan can approach a service plan if an adequate number of physicians agree to the fee schedule (participate), and the upper limit of income is high enough that a large majority of the subscribers are not subject to extra billing.

Experiences with voluntary health insurance and the Medicare and Medicaid programs have prompted a widely varying series of related legislative proposals. From November, 1969 to August, 1970, five national health insurance plans were presented to Congress and are currently receiving consideration.

These proposals illustrate the spectrum of approaches, described above, from service benefits to cash indemnity benefits. Two proposals, the Reuther Plan (now the Kennedy Health Security Program) and the Griffiths (AFL-CIO) Plan, are service benefits government operated plans. [98] The AMA Medicredit and Pettengill proposals are cash benefits private insurance plans, and the Javits Bill represents a compromise between the public and private, and service and cash approaches. Table VI is a resume comparison of these proposals from most "liberal" (Reuther) to most "conservative" (AMA).

TABLE VI

Comparison of Five Proposals for National Health Insurance*

PROPOSALS	GENERAL APPROACH	COVERAGE	BENEFITS	ADMINISTRATION
(1) Committee for National Health Insurance (Reuther)	Government universal health insurance program financed by payroll tax and general revenues.	U.S. residents	Comprehensive health benefits Major exclusion is dental services for adults. Limitations on podiatrists' services, drugs, nursing home, and mental health care. No cost-sharing.	Federal board under Department of HEW; regional offices; advisory bodies.
(2) Griffiths Bill (AFL-CIO)	Government universal health insurance program financed by payroll tax and general revenues	U.S. residents	Comprehensive health benefits Major exclusion is dental services for adults. No cost-sharing except for physician, dentist and other ambulatory services. ($2 co-pay per visit, with certain exceptions.)	Federal board composed of HEW officials and non-government members; regional offices; advisory bodies.
(3) Javits Bill	Government universal health insurance program (similar to Medicare) with option of "electing out" by purchase of private insurance.	U.S. residents	Same as Medicare (hospital, physician, nursing home, etc. subject to cost-sharing and limitations). Also annual check-ups, limited drugs, and dental care for children under age eight.	Department of HEW (as under Medicare) or, under contract with HEW, by state government. Processing of claims conducted by private carriers (as under Medicare) or, under certain conditions, by special quasi-government organizations.

TABLE VI (cont'd)

PAYMENT OF PROVIDERS	FINANCING	COST
(1) Physicians and dentists; Regional funds allocated first to those in group practice or selecting capitation, salary, or per session basis. Residual allocated to local payment authorities to pay those selecting fee-for-service or per case basis. Hospitals, nursing homes, home health agencies; Negotiated budget designed to pay reasonable cost under efficient organization.	Tax equal to about 7-3/4 percent (on 1969 basis) including 2.8 percent on employers, 1.8 percent on employees and on non-wage income, and general revenues payment equal to 3.1 percent. Tax levied on first $25,000 of employees and non-wage income combined, and on total payroll per employers.	Cost would have been $37 billion in fiscal 1969, according to CNHI.
(2) Physician and dentist groups can contract to receive pre-determined payment and pay their members as they choose (including fee for service). Individual primary physicians and dentists may elect per capita, salary, or combination of methods and receive an allowance to pay for services of specialists and other health professionals. Hospitals; Negotiated budget that includes allowance for nursing home and home health services.	Tax equal to 7 percent of payroll, including 1 percent on employees, 3 percent on employers, and a payment from general revenues equal to 3 percent. Earnings base of $15,000, adjusted automatically to increases in wage levels	Cost would have been $35.8 billion in fiscal 1969, according to AFL-CIO.
(3) Until July 1, 1973, reasonable cost for hospital and institutions and reasonable charges for physicians (as under Medicare). Thereafter, new methods, developed in interim, may be employed.	Tax equal to 10 percent of payroll, including 3.3 percent on employers and 3.3 percent on employees and payment from general revenues equal to 3.3 percent. Tax levied on $15,000 earnings base for employees and on total payroll for employers.	Cost of $22.7 billion in 1975, according to Social Security actuary.

TABLE VI (cont'd)

PROPOSALS	GENERAL APPROACH	COVERAGE	BENEFITS	ADMINISTRATION
(4) Pettengill** Proposal	Private insurance for poor or related groups through an insurance pool subsidized by government.	Poor, near poor, and uninsurables (voluntary)	Statewide uniform benefits. Minimum benefits to be specified in Federal law and to include ambulatory and institutional care.	Statewide insurance pool administered by carrier selected by state with concurrence of federal government.
(5) AMA Medicredit	Income tax credits to off-set cost of qualified private health insurance.	U.S. residents (voluntary)	To be qualified, policy must include basic hospital and physician benefits, and may optionally offer supplementary drug, blood, hospital and other benefits. Benefits subject generally to cost-sharing and limitations.	Federal advisory board (including HEW, IRS, and nongovernment members) to establish federal standards for use by state insurance departments in approving private insurance plans.

TABLE VI (cont'd)

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TABLE VI (cont'd)

PAYMENT OF PROVIDERS	FINANCING	COST
(4) Present methods under private insurance.	Poor would pay no premium and the near poor and uninsurables would pay part of the premium. State and federal general revenues would finance the balance of the cost of the program.	Estimates not available.
(5) Present methods under private insurance.	Financed from federal general revenues.	Net cost for 1970 estimated at $8 billion by AMA and at $15 billion by SSA

* Source: Social Security Administration; cited in Schorr, op. cit., pp. 178-80.

** Mr. Pettengill is Vice-President of Aetna Life and Casualty Insurance Company.

V. CONCLUSION AND A CAVEAT FOR THE PUBLIC

The complexity of the current situation in health care and medical services in the United States precludes defining a problem or the issue. It is not merely a "shortage or maldistribution of physicians;" nor a "dysfunction in the organization, productivity and delivery" of health care; nor "inadequate cost controls" or "ineffective payment plans." It is each of these at once, inextricably set in a pattern of social, professional and economic parochialisms and political expediencies. There exists in America a generally excellent (and well-publicized) health care capability and the potential for expanding this capability with little identifiable sacrifice in quality. There exists a significant segment of the population -- poor, near-poor, fixed and middle-income groups -- who are increasingly in need of health service benefits. With these premises, a statement of the central issue might be, "how can the existing and potential capability be applied to the existing need?"

Two barriers impeding the public's access to more adequate health care and medical services have been identified; the financial barrier and the proximity or geographical barrier. These barriers are very real, near-national in scope and cast in the inertia of existing parochial and expedient attitudes; but they should not be considered impregnable. The advent of change will likely evolve from

public reaction. The growing medically needy are a growing political constituency, no longer appeased by the simplistic rhetoric of "more physicians of the highest quality," "improved institutional efficiency and teamwork," and trite Madison Avenue catch phrases heralding more expensive and increasingly deficient health insurance schemes. Change has become inevitable; the manner in which change occurs is the vitally important question.

America's future health care system will directly reflect the nature of the struggle for change. Some form of government sponsored national health insurance will come into being. But it seems self-evident that if such a scheme is cash indemnity oriented, or relies on the private insurance industry, it will lead progressively to increasing costs and chaos, accompanied by minimal benefits, and in turn to increasing federal control of health insurance and services, and thus to increasing centralization. Over-reaction to a repeat of the Medicare and Medicaid experience, magnified several times by application to the entire population, might lead swiftly to a thoroughly socialized system in the sense of a nationalized health service. In contrast, a proposal which appears more 'radical' now, but provides health service benefits within budgetary constraints, may achieve much less centralized regulation and lead to a more 'moderate' solution.

The nature of change and the resulting system will reflect the attitudes of the medical professions and related

economic and political entities. Unfortunately, past experiences, attitudes and behavior patterns bodes ill for a moderate solution. On some future date fiscal controls will be implemented and the affected fee and price levels will be initially set, most likely, at the average for a particular time span. In anticipation of this event, it is in the interest of the health care professionals, institutions, and related industries to delay its occurrence and concurrently escalate fee and price levels to the maximum extent possible. Hence, three of the proposals presently before congress are basically cash indemnity approaches utilizing private health insurance as intermediaries or carriers. Plans designed such as these, if subsequently enacted, would likely be viewed in retrospect as ineffective and costly delays on the road to comprehensive national health service benefits (or to socialized medicine). Other more subtle forms of delay may call for the situation to be 'studied' to find an 'optimal' or 'best' solution. In August 1973, the Rand Corporation began such a study, "to help formulate a health care financing plan for the nation." The president of Rand stated that the study could cost $30 million over an eight year period. [99]

A lesser struggle and more moderate solution may be envisioned but, admittedly, only with a significant degree of idealism with regard to the political structures of health care providers and related interests. Certain key elements would evolve other major developments impacting on

the financial and proximity barriers to more adequate health care. Some of the key elements are:

- Expansion of the number of physicians and other health care personnel, and redesign of new and existing source institutions (as in the Carnegie Commission recommendations).
- Elimination of prohibitions and restrictions on group practice.
- Enactment of a comprehensive, government sponsored, universal health insurance program, designed as a health service benefits plan.

The insurance statute would make each individual a member of a prepaid group health benefits plan and effectively equalize the paying ability of the public in all geographical areas. Pockets of inherently well-to-do and high income persons could continue to go 'first class' with supplementary private insurance, but would attract a lesser proportion of expanded health care resources. The plan would affect cost controls and budgetary constraints in the sense of standardized fee and price schedules and institution and group practice contracted budgets. Some of the major developments to be expected are:

- A national redistribution of health care personnel and institutional resources.
- Development of innovative and efficient medical practice and institutional organizational forms: incentives for augmenting the number of general family physicians;

multispecialist groups with their own or affiliated facilities; expansion of hospitals into comprehensive health maintenance and service systems; community hospital centers with affiliated neighborhood health centers; comprehensive primary care complexes (if the insurance plan required patients to register with a primary physician or group).

Of most importance is the objective of improved medical care at reasonable cost to more of the population. A prepaid health service benefits plan can direcly affect and control two conditions permitting improved soundness of medical care; one, the use of physicians' services is determined by the patients' or subscribers' health needs; and two, the kinds and amounts of services which physicians render are determined by professional standards rather than by the patient's ability to purchase services. The first condition implies that the patients and physicians become health maintenance oriented, and the second condition implies the rendering of care and services on the basis of medical rather than cost considerations.

The form of administration and control of this conceptual system will likely reflect the attitudes of organized medicine and related interest groups. Bitter and costly prior experiences may dictate a highly centralized bureaucratic system at the federal level. A decentralized system -- a federal level policy board, regional regulatory and advisory boards, and localized area control boards --

reflecting a synthesis of professional and consumer needs from federal to local level would be more in the public's interest. However, design of such a system would require strong medical profession participation and support with commensurate consumer involvement.

As the respective positions of the public and private sectors become more distinct, the prospects for a more moderate solution are deteriorating. The Carnegie Commission, in writing its special report, envisioned extensions of federal financing not only for medical education, but also for broad health care services and delivery systems, and a national health insurance program. On the other hand, the carefully worded AMA-AMMC joint statements, although explicitly soliciting federal funding, also solicit mobilization of support from local -- city, county and state -- levels, and private -- individuals, industries and foundations -- sources. Federal funding is advocated for "the education component of medical center activity," construction, operation and educational innovation in medical centers, medical student subsidies, operational cost of medical schools, and for research. Collectively, with AMA advocacy of funding medical care through expansion of the existing inflationary and ineffective approaches, this simplifies to a process of dropping more and more billions into the present system for financing the sources and purchasing resources.

Evidence of a possible turnabout on the physician issue and further indications of the professional hard-line on

health care benefits emerged at the 1973 AMA annual convention. In his opening address, the president of the AMA labeled the nationwide shortage of physicians "a dangerous hoax" that misstates the problem, misleads the public, and creates false hopes. "Numbers are not the problem and never have been.... with 133 direct-care physicians per 100,000 persons, America is well on its way to meeting the actual need for physicians." Despite popular belief, America faces only improper distribution of physicians -- too many in certain urban areas, too few in rural communities and urban ghettos, the AMA president explained. [100] Also in his opening remarks, he attacked the Kennedy-Griffiths health insurance bill as an "insidious threat" to the quality of medical care. [101]

At the same time the AMA released the results of a survey showing that three doctors out of five who responded were dissatisfied with the amounts of money they were being paid under the Medicare program; and a third of the doctors who responded said they would either refuse to practice in a nationalized health system, or would leave the practice of medicine altogether if such a system were created. These results are from an AMA survey of a segment of its own membership. [102] Negative and scare propaganda has long been a characteristic of the AMA, but could such attitudes be generalized proportionately to the entire medical profession, as the AMA desires, then it would be all the more reason to accelerate the expansion of the number of physicians. Doctors holding such views would hopefully abandon

the profession and be replaced by ones with concern for the patients' health care. Seemingly in response, the California Medical Association released the results of a small survey indicating that future California doctors may shun large hospitals in favor of practicing in isolated rural or urban ghetto areas. Of 700 medical students and recent medical graduates surveyed, half of the 500 who responded said they would like to practice in rural areas, and a fourth said they would like to work in ghettos; the students polled were less inclined toward specialization than direct primary care; and the younger students heavily favored "some form of national health insurance." [103] Such news is refreshing but should create only limited optimism; students' constructive intentions and ideals must withstand a consistent barrage of AMA-AMMC influence during formative and subservient years.

Clearly the political structure of the private sector prefers expansion of existing systems for the enhancement of personal incomes and corporate profits at the expense of adequate health care for the public. The absurdity of this situation is exemplified by the fact that elderly patients pay more out-of-pocket costs for medical care now than before Medicare was enacted. The government's own figures show that the average personal payment for Americans aged 65 and over has grown from $234 in fiscal 1966, the year before Medicare began, to $276 for fiscal 1972. [104] The growing public medical constituency hopefully, will not long ignore such greed and callousness, nor such a situation as medical

profession institutional ownership of large blocks of stock in the drug industry. [105] The AMA, whose journal draws heavy income from drug ads and whose pension fund has $10 million in drug stock, recently refused to publish an ad for the book: Physician's Guide to Prescription Prices, which gives doctors and consumers comparative costs of drugs. In explanation, the AMA told the book's publishers, "we would not presume to encourage efforts to 'fix' prices...." But by refusing the ad, the AMA perpetuates precisely that practice. [106]

Present federal medical and health related expenditures are likely only a modest beginning. The American public may, a decade or so hence, find itself funding production and distribution of all of the nation's health care and related resources. It would indeed be unfortunate if the same public were then trying to purchase these publicly financed resources in a falsely inflated and profit maximizing environment, fostered and dominated by a discriminating medical monopoly, and controlled by para-political professional associations with their biased interests and seeming indifference to the issue of adequate health care benefits for the population. It appears infinitely more reasonable that the public will insist on a national health service benefits system in response to progressive nationalization of health care sources.

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75. Ibid., pp. 3-4.

76. Medicare and Medicaid Hearings, July 1969, op. cit., p.3.

77. Total expenditures on health and medical care in 1968-69 were $60.3 billion. Of this $37.7 billion represented private expenditures; public expenditures were $22.6 billion, 37.5 percent of total; federal expenditures were $15.1 billion, while state and local public expenditures were $7.5 billion. Barbara S. Cooper, "National Health Expenditures," Research and Statistics Note, November 1969, tables 2, 3.

78. U.S. Congress, Senate, Committee on Government Operations, Subcommittee on Executive Reorganizational and Government Research, Health Activities: Federal Expenditures and Public Purpose, Committee Print, 91st Cong., 2nd sess., June 1970, pp. 11-12, 127-39, and passim.

79. Cited in Stevens, op., cit., p. 505.

80. Notable examples were in Vallejo, California, and Belle Glade, Florida, Health Activities, op. cit., pp. 23-25.

81. The foregoing content of this thesis seems quite consistent with economists' textbook views of a monopoly in microeconomic theory, namely:

- Society's limited resources are used relatively less efficiently in monopoly markets than in competitive markets.

- In a monopoly market, society as a whole would benefit by having more of its resources used in producing the commodity in question.

- The profit-maximizing monopolist will not produce at a more efficient point for to do so would eliminate some profit.

Additionally, the social service nature of health care appears an appropriate field for that which economists' describe as a 'natural' or a 'market franchise' monopoly. The term natural monopoly implies that the natural result of market forces is the development of a monopoly organization (e.g., public utility services). A franchise monopoly is frequently associated with a natural monopoly, but need not be. The market franchise is actually a contract entered into by some governmental body and a business concern. The governmental unit gives a business firm the exclusive right to market a good or service within its jurisdiction. The firm, in turn, agrees to permit the governmental unit to control certain aspects of its market conduct. The usual cause underlying development of these monopoly markets is the excessive amount (cost) of a society's resources which would be required to foster competitive markets.

82. Much of the information in this section is abbreviated from: Rosemary Stevens, op. cit. and Medical Practice in Modern England, Yale University Press, New Haven and London, 1966, passim; Harry Eckstein, The English Health Service, Harvard University Press, Cambridge, Mass., 1958; Schorr, op. cit.; and miscellaneous periodicals from 1970 to date.

83. This program appears to have considerable relevance for U.S. medical practice and economics. For a thorough description and evaluation of the Windsor plan, see: B. J. Darsky, Nathan Sinai, and S. J. Axelrod, Comprehensive Medical Services under Voluntary Health Insurance, President and Fellows of Harvard College, Harvard University Press, Cambridge, Mass., 1958.

84. Quoted in Schorr, op. cit., p. 158.

85. Kennedy, op. cit.,pp. 221-22.

86. The Carnegie Commission on Higher Education, Higher Education andthe Nation's Health; Policies for Medical and Dental Education, The Carnegie Foundation for the Advancement of Teaching, McGraw-Hill, Hightstown, N.J., 1970, passim.

87. Ibid., p. 36.

88. Ibid., p. 13.

89. Ibid., pp. 3-5. Notwithstanding that Flexner's study was sixty years old, this critique of the Flexner model is surprising only in that it has not been stated more often and more forcefully. The 'Flexner Report' and Flexner model serves to illustrate a difference in perceptions between the AMA and the public. The AMA considers that among the most important contributions that the association made to the improvement of medical education was the assistance it gave to Flexner in his investigation of American medical schools. The editor of the AMA Journal advised Flexner on problems related to his difficult assignment, and N.P. Colwell, secretary of the Council on Medical Education, made available its many reports and accompanied him during his investigations. The 'fearless exposure' of deficiencies in medical education rested in great measure on the contributions of the AMA.

    On the other hand, a not insignificant number within the medical profession and a segment of the knowledgeable lay public view Flexner's study in a different light. Flexner toured American medical schools on behalf of the Carnegie Foundation to see how closely their teaching methods conformed to those of John Hopkins. Flexner had a BA degree and operated a prep school; he wasn't a physician, scientist, or medical educator. As a result he relied heavily on the AMA's Council on Medical Education -- and his report to the Carnegie Foundation reflected this reliance. Flexner ignored the caliber of the various medical schools' graduates and concerned himself only with methods of standardizing curriculum and technique. Not surprisingly, it turned out that the best way was the AMA way. Soon after the report, state boards of medical examiners -- staffed with AMA doctors -- were instituted to decide (1) the contents of each state's licensing exam, and (2) who was qualified to take the exam. In 1906, the Council had 'approved' 130 medical schools as acceptable; by 1930 the number was 76. The detrimental impact of this evolution is inestimable.

For example, after Flexner's report, the number of predominantly Negro medical schools decreased from seven to two -- from which 85 percent of all Black doctors have been graduated.

90. Ibid., p. 10.

91. Ibid., p. 61.

92. Ibid., p. 66.

93. Ibid., p. 32.

94. Ibid., pp. 18, 61.

95. Ibid., p. 15.

96. Representatives of the Board of Trustees of the American Medical Association and the Executive Council of the Association of American Medical Colleges: joint statement issued March 5, 1968 following a meeting held in Chicago on February 28, 1968; second joint statement issued April 16, 1968; ibid., pp. 101-06.

97. Burrow, op. cit., p. 393. Although Mr. Burrow is an admitted proponent of AMA policies and principles, he thoroughly condemns past AMA propaganda methods. He is highly critical of the publishing of distorted and misleading accounts of the operation of compulsory systems abroad, particularly of the British system during its perilous early stages. Ibid., pp. 345-47.

98. Through minor compromise, the 1970 Reuther and AFL-CIO proposals are now formulated into one bill, the Health Security Program.

99. Associated Press, "Rand 'Think Tank' Tackles Health Care," in the Monterey (Ca.) Peninsula Herald, 1 September 1973, p. 6.

100. Michael Woods (of the Toledo (Ohio) Blade), "Doctor Shortage a Hoax, AMA Head Warns," in the Monterey (Ca.) Peninsula Herald, 25 June 1973, p. 1, 5.

101. Richard D. Lyons, "Third of AMA Doctors Polled Would Boycott National System," New York Times, 25 June 1973.

102. Ibid. The only sampling figure noted was "almost 100,000 physicians." The actual number surveyed and number responding was not disclosed.

103. Associated Press, "Future Trend for Doctors Services Told by CMA," in the Monterey (Ca.) Peninsula Herald, 26 July 1973, p. 3.

104. Associated Press, "Medicare Patients Pay More Costs Now With Own Money," in the Monterey (Ca.) Peninsula Herald, 24 July 1973.

105. Richard D. Lyons, "Stocks in Drugs Held by A.M.A.," New York Times, 26 June 1973.

106. Jack Anderson, "Hospital Stay", in the Monterey (Ca.) Peninsula Herald, 5 July 1973.

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The author examines the Department of Defense program to procure and retain physicians for the armed forces. The necessity for such a program is shown to be related to the medical profession's policy of restricting entry into the profession; the resulting shortage of physicians is found to be inseparable from the national issues of health care productivity and delivery, and the present inadequacies of health care financing. A

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statement of the central issue is formulated, the main barriers to be overcome are identified, and a politically moderate solution is proposed through adoption of certain key policies. Such a solution is described as unlikely since it requires the support and participation of the medical profession. The alternative is a later and more severe public and political reaction, leading to an increasingly centralized national health service system.

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